Worcestershire Acute Hospitals NHS Trust

Bereavement Care Guideline for Management of Women and their Family Experiencing the Loss of a Baby

Owner: Trudy Berlet Stephanie Beddall Sam Agwu	Job title: Lead Bereavement Midwife Bereavement Midwife Consultant Obstetrician & Gynaecologist
Approved by Maternity Quality Governance Meeting on:	21st August 2020
Review Date This is the most current document and should be used until a revised version is in place:	4th June 2025

Key Amendments

Date	Amendment	Approved by
June 2020	Bereavement guidelines merged	
November 2021	Misoprostol comments added to point 6.6	LWF/ Obstetrics Governance
4th June 2024	Document extended for another 12 months whilst under review	Maternity Governance

Contents

1. Introduction

The loss of a baby in pregnancy or shortly after birth is an immense trauma for the family involved. What happens to them and the care they receive during this time will stay with them forever, the memory of this will become entwined with the memory of their child. As such the provision of sensitive, high quality care is imperative.

2. Objectives

This document aims to provide guidance and support to all staff involved in caring for the woman and her family during the antenatal, intrapartum and postnatal period. Our aims are that the women and their families experiencing the death of a baby or a baby that is dying are provided with sensitive, supportive, high-quality care.

3. Policy Scope

This guideline applies to all nursing, midwifery and medical staff who may be involved in the care of women and their families before, during and after the loss of their baby. This may be a miscarriage, stillbirth, neonatal death or termination of pregnancy.

4. Definitions

4.1 Intrauterine Death (IUD)

The absence of cardiac activity in the fetus while in-utero.

4.2 Miscarriage

A baby born before 24 completed weeks of pregnancy with no signs of life. Where an intrauterine death is diagnosed on ultrasound before 24 weeks (RCOG, 2005).

4.3 Stillbirth

A baby born after 24 completed weeks of pregnancy with no signs of life.

4.4 Neonatal death

A death that occurs before the age of 28 completed days of life, this can be further split into an early or late neonatal death. An early neonatal death is the death of a live born baby before 7 completed days of age. A late neonatal death is the death of a live born baby after 7 completed days but prior to 28 completed days of age (MBRRACE, 2016). A baby of any gestation that shows signs of life following complete expulsion from the mother, regardless of whether or not the cord has been cut.

4.5 Bereavement Suites

At Worcestershire Royal Hospital, there are two Bereavement Suites that are able to be used by families, Snowdrop Suite and Forget Me Not Suite. These rooms are situated just off Delivery Suite away from the noise to give privacy to families. There is a locked cupboard outside of Snowdrop Suite which is full of blankets, clothes, memory boxes and much more to be used for the families in our care. The code for this cupboard is on Delivery Suite and known by the Band 7 Coordinators.

5. Duties and Responsibilities

5.1 Bereavement Support Midwives

- Provide training to midwifery and medical staff to enable them to carry out individualised care to families experiencing the loss of a baby.
- Provide families experiencing bereavement with written information, advice and support in all aspects of certification, post-mortem consent and arranging funerals for their baby
- Postnatal support for families in their home and over the phone

5.2 Midwives

- Detect IUD on auscultation
- Diagnosing an IUD on USS if trained to do so
- Breaking bad news and answering any potential questions that families have
- Referring to appropriate consultant/medical staff for medical plan
- The coordinating midwife on Delivery Suite is responsible for ensuring that midwives are allocated sufficient time to provide care for families experiencing loss
- Providing antenatal, intrapartum and postnatal care in line with the medical management plan and relevant trust guidelines
- Providing support to bereaved families around the time of the death of their baby
- Completing all relevant documentation including certificates
- Informing the Bereavement Support Midwives of any bereavement, this is regardless of whether the family wish to see the team or not.
- Following the bereavement checklist and informing the relevant agencies of the situation
- Post-mortem consenting if trained to do so

5.3 Medical Staff

- Diagnosing an IUD or fetal abnormality if trained to do so
- Breaking bad news and answering potential questions that families have
- Formulating a plan of care
- Post-mortem consenting if trained to do so
- Complete relevant documentation and certificates

5.4 Neonatologists

- Decision making relating to withdrawal of care and communication with families
- Breaking bad news and answering potential questions families may have.
- Formulating a plan of care
- Complete relevant documentation and certification, this may include a referral to the coroner
- Post mortem consenting

5.5 Radiographers

- Detecting IUD or fetal abnormality
- Reporting on the placental site in the scan report to aid care planning
- Breaking bad news and answering potential questions families may have
- Refer to appropriate consultant for medical plan

6. Procedure

6.1 Principles of good practice

- Care should be parent led. Identifying and meeting the needs of parents should be regarded as an investment in their future health and wellbeing.
- Good care involves spending extra time with parents. This should be recognised by managers and staff.
- Each parent's personal preferences and cultural or religious needs should be taken into account.
- Communication with parents should be clear, sensitive and honest, and should be tailored to meet individual needs. Trained interpreters and signers should be available for parents who need them. Interpreters should be booked in advance wherever possible, and the interpreting telephone used when this is not.
- It is important that staff accept, acknowledge and validate the feelings that individual parents experiencing their partner's grief may be as profound as that of a mother; and their needs for support should be recognised and met.
- Many childbearing losses involve periods of uncertainty. Staff should avoid giving reassurances that may turn out to be false. They should acknowledge the difficulty of living with uncertainty
- In any situation where there is a choice to be made, parents should be given the information they need, and should be supported and encouraged to make their own decisions about what happens to them and their baby.
- Women should be cared for in a place that is appropriate. Ideally women and their families should be cared for within the bereavement suites. Where other delivery or HDU rooms need to be used then this should be done with sensitivity and all fetal monitoring and resuscitation equipment removed from the room (room 8 and 9 should be used for labour / HDU care). Any reference to breastfeeding information should be removed also. Women can be admitted to the Bereavement Suite from the postnatal ward also if required.
- It is recommended (Sands Audit tool 2011) that women and their partners should be looked after by staff who are trained to deal with not only their clinical care and physical needs, but also with their emotional needs.
- Ongoing support is part of care and should be available to all those who want it, regardless of the timing and type of loss that they have experienced. Support should continue to be available to all women and

their partners during subsequent pregnancy and after the birth of another baby.

- All staff that care for parents during and after a loss should have the opportunities to develop and update their knowledge and skills, and should have access to good support themselves.
- Priority should be given to maintaining a family's privacy, however all members of staff likely to come into contact with the family including housekeeping and support staff should be informed of the situation.

6.2 Diagnosis of IUD

- An honest, sensitive and sympathetic approach is vital and can be a major factor in how the woman and her family grieve and cope over the time to come.
- Where there is suspicion of IUD the mother should be attended to as soon as is practicable.
- If the woman is seen in the community setting and the fetal heart is not audible then the midwife should contact Delivery Suite and arrange for the woman to be seen straight away.
- The diagnosis must only be made when confirmed by ultrasound scan. The ultrasound must only be performed by two appropriately qualified individuals to confirm intrauterine death.
- If difficulty confirming diagnosis of IUD on Delivery Suite USS machine, a departmental USS should be organised in a sensitive manner for the family and the woman should be accompanied to this scan.
- Assistance should be given to the woman if she is alone at the time to contact family or a friend for support. A member of staff should be available at all times.
- If unable to locate the fetal heart on the antenatal ward, the woman should be transferred to a side room for an USS to confirm IUD. If there are no side rooms available, she should be transferred to Delivery Suite.
- The diagnosis of IUD may also happen in the main scan department, fetal medicine department or in antenatal clinic (ANC). A dedicated quiet room is available for counselling and discussion with the woman and her partner if present. Following full discussion with the woman regarding plan of care and possible induction of labour, she will be given the option to remain in hospital or return home. If the woman is clinically unwell, for example, pre-eclampsia or pyrexial she will be transferred to delivery suite for closer monitoring.
- When an IUD is confirmed in triage or DAU then the woman can be transferred to the quiet room in Antenatal Clinic or a Bereavement Suite on Delivery Suite, to allow for privacy and further discussion regarding care.
- If an IUD is confirmed, the member of staff caring for the woman should liaise with the shift leader on Delivery Suite to arrange transfer of the woman, preferably to the Bereavement Suite.

- On transfer to delivery suite, following diagnosis of IUD, every woman will have an individual named midwife. Care will ideally be provided on a one to one basis.
- A senior member of the medical team on delivery suite (ideally the consultant or ST 6 or above) should be informed and attend promptly.
- The woman's named team (consultant or midwifery) should be promptly informed by the midwife.
- Many women will want to know what will happen next, and this subject will need to be broached with the family even if they do not ask themselves. It is important that this information is given in a sensitive but honest manner. If available a member of the Bereavement team on extension #30583 can be contacted to assist if staff think it appropriate, some families may have many questions at this time.
- Women should be informed that vaginal birth is recommended as there are fewer risks to the woman; you will be able to go home more quickly, recovery is likely to be quicker and more straightforward and future pregnancies are likely to have fewer complications (RCOG 2012). Most women will be shocked by this and questions should be encouraged and welcomed.

6.3 Immediate Management Following Confirmation of IUD

- A full set of baseline observations (BP, pulse, temperature, respiratory rate, and urinalysis) should be performed and recorded on a MEWS chart.
- Inpatient maternal observations should continue, as a minimum, four hourly, or as clinically indicated. (Two hourly once treatment with Misoprostol has commenced)
- If the woman is well with intact membranes then it is acceptable that she might want to go home before taking any decisions about induction of labour. It is vital that she is given a 24 hour contact number (Delivery Suite) to call when they are ready to make a decision or if they require further information.
- If physically well the process of inducing labour can be commenced on the day of diagnosis by giving the initial dose of Mifepristone with the woman returning home for 36-48 hours before admission to delivery suite.
- If the decision is going to be delayed for more than 48hours regular contacts are essential. This is to assess the clinical condition, by taking maternal observations, including urinalysis. Blood tests, including clotting and FBC will be taken to monitor for disseminated intravascular coagulation (DIC) (RCOG 2012). Women should be advised that delays of more than 48 hours can increase the risk of DIC, affect the accuracy of post mortem examination and that the appearance of the baby may deteriorate with time.
- The Sands booklet "Bereavement Support Book" (Sands 2019) as well as the Trust 'Bereavement Support following the Death of Your Baby' (WAHT-PI-0524)(Appendix 1) leaflet should be provided. There is a space for written notes in the back, this can be used for contact

numbers, written instructions of what to be aware of when at home after commencing Mifepristone.
- The patient information leaflet 'What to Expect When Coming in for Medical Management of Induction of Labour' (WAHT-PI-0824) (Appendix 5)
- Women should be advised that may still feel as though their baby is moving. This is caused by the 'shifting' movements of the baby within the amniotic fluid. This can be very distressing for women. (RCOG 2012).

6.4 Communication Following Diagnosis

- Where it is known that an intrauterine death has occurred or termination of pregnancy is taking place the woman should be given sensitive but honest information about what to expect in labour
- If needed, interpreters should be arranged in advance if possible, the telephone interpreting service can also be used
- Information may need repeating as in times of trauma families may not remember every discussion they have had
- Time should be given on admission to delivery suite to go over the induction process again and answer any questions. However, in some cases there is no time for detailed discussion prior to labour and delivery, effective communication is of paramount importance at such a frightening time.

6.5 Investigations Required

- Many women will welcome the opportunity to have the cause of the death of her baby investigated.
- Some of the tests should be carried out as close to diagnosis as is possible and some will take place in the weeks following (see below).
- Additional tests may be required and will be specified by medical staff in the individualised management plan.

6.5.1 Tests to be Taken at the Time of Diagnosis of IUD

IUD bloods should be taken for all women at time of diagnosis, please see the IUD panel on ICE for all bloods that are included. Results of haematology should be checked prior to discharge home if patient is returning home before induction.

FBC & Clotting

- The woman must remain in hospital until the results are available.

Kleihaur

- Must be taken regardless of whether RhD positive or negative
- If RhD positive make it clear on the request form that the woman is RhD positive and has had a pregnancy loss.

- In RhD positive women a positive Kleihaur can aid in the diagnosis of feto–maternal haemorrhage, if delayed, the result is inaccurate as red cells can clear quickly from the maternal circulation
- For RhD negative women if the bleed has taken place sometime before diagnosis, it is vital to get a result as soon as possible so that the optimal amount of Anti D can be given. Anti D should be given on diagnosis of IUD (following Kleihaur) as well as post-delivery.
- For terminations of pregnancy, Anti D should be given at the time of Mifepristone administration as this may cause a sensitising event, as well as post-delivery.
- For RhD negative women if there has been a large feto-maternal haemorrhage, then the test should be repeated at 48hrs
- For RhD negative women a postnatal Kleihaur will also need to be obtained.
- **ALL** RhD negative women should be offered postnatal Anti D, regardless of if they have had a 'Free Fetal DNA' (FFDNA) test. As we are unable to confirm the blood group of the baby with cord blood, the risk to future pregnancies is felt to be bigger than the risk of administering Anti D unnecessarily.

TORCH and Parvovirus
HBA1C – regardless of if they were diagnosed diabetic in pregnancy
HVS, Chlamydia and Herpes swabs – to be taken with first dose of PV misoprostol
TFT's
Anticardiolipin (IgG) ABS
Lupus Anticoagulant screen
Bile Acids
Midstream Urine
LFT's
Group and Save

Additional Investigations, depending on clinical condition.

- Biochemistry (renal function, CRP etc.)
- Blood cultures

6.5.2 Test to be taken approximately 8-12 weeks after birth

Thrombophilia screen
FBC
Thyroid function test – If previous abnormal or borderline result
Lupus Anticoagulant – If previous abnormal result
Anticardiolipin ABS – If previous borderline or abnormal result

6.6 Induction of labour with Mifepristone and Misoprostol

- If the woman is unwell, consider giving the Mifepristone and the first dose of Misoprostol simultaneously. The regime then can continue 3-6 hours afterwards. This should always be a consultant decision.

- Once prescribed, Midwives can administer both the Mifepristone and Misoprostol
- In cases of termination of pregnancy, prior to giving Mifepristone the Midwife must check that ALL the required forms have been correctly completed before proceeding. Certificate A (blue form, HSA1) must be completed and signed by two medical practitioners, the Abortion Notification (Yellow form, HSA4) must be completed and signed by the lead medical practitioner in the case. A Worcestershire Royal Hospital blue consent form must be completed and signed by a medical practitioner and the woman. Signatures must be recognisable and legible. Once this is all complete, the Mifepristone can then be given.
- Maternal observations should be carried out 4 hourly until the commencement of Misoprostol; it should then be 2 hourly until delivery.
- **In cases of previous uterine surgery or grand multiparity the case must be discussed with the consultant in charge of Delivery Suite.**

Mifepristone

- Administer oral mifepristone 200mg. Patient should be asked to remain on the ward for at least 20 minutes to be monitored for any vomiting. If she is well after 20 minutes she can be allowed to go home with a full explanation of procedure, what symptoms to expect i.e. nausea and mild discomfort, please give the Mifepristone leaflet that is on Delivery Suite together with a contact number for the ward which she can ring if she has any concerns and a time and date to return. The patient should be advised that she may take mild paracetamol based analgesia (TTOs to be provided) but to avoid NSAIDS.
- 36 – 48 hours following Mifepristone admit to Delivery Suite.
- If possible the woman will be admitted in the morning
- **On readmission, a full set of observations should be taken as well as bloods for FBC, clotting and group and save before starting the induction process.**
- Administration of oral Mifepristone is only required for women undergoing termination of pregnancy at any gestation or a miscarriage >16 weeks' gestation. Women under 16 weeks diagnosed with miscarriage can proceed directly to misoprostol treatment

Administration of Misoprostol:

- Misoprostol is equally effective when administered orally/ sublingually or vaginally. Evidence suggests that vaginal misoprostol has lesser side effects. Repeat doses of misoprostol after the first vaginal dose can be given orally/ vaginally depending on the patient preference.

- **< 24 weeks gestation**
- Administer Misoprostol 800 micrograms PV
- 3 hours later give 400 micrograms orally and continue 3 hourly to maximum of 4 further oral doses (total of 6 doses of Misoprostol).
- **In cases of previous uterine surgery (such as previous LSCS) or grand multiparous, the case must be discussed with the delivery suite**

consultant. Halve Misoprostol doses and increase administration time to 6 hourly

Unscarred uterus	Scarred uterus/ grand multiparous
Mifepristone 200mg PO	Mifepristone 200mg PO
36-48hrs later Misoprostol 800micrograms PV	36-48hrs later Misoprostol 400micrograms PV
3hrs later Misoprostol 400micrograms PO	6hrs later Misoprostol 200micrograms PO
3hrs later Misoprostol 400micrograms PO	6hrs later Misoprostol 200micrograms PO
3hrs later Misoprostol 400micrograms PO	6hrs later Misoprostol 200micrograms PO
3hrs later Misoprostol 400micrograms PO	6hrs later Misoprostol 200micrograms PO
3hrs later Misoprostol 400micrograms PO	6hrs later Misoprostol 200micrograms PO

- **24-34 weeks gestation**
- Administer Misoprostol 200 micrograms PV
- 3 hours later give Misoprostol 200 micrograms orally and continue 3 hourly to maximum of 4 further oral doses. (total of 6 doses of Misoprostol)
- **In cases of previous uterine surgery (such as previous LSCS) or grand multiparous, the case must be discussed with the delivery suite Consultant. Give same Misoprostol doses and increase administration time to 6 hourly.**

Unscarred Uterus	Scarred uterus/ grand multiparity
Mifepristone 200mg PO	Mifepristone 200mg PO
36-48hrs later Misoprostol 200micrograms PV	36-48hrs later Misoprostol 200micrograms PV
3hrs later Misoprostol 200micrograms PO	6hrs later Misoprostol 200micrograms PO
3hrs later Misoprostol 200micrograms PO	6hrs later Misoprostol 200micrograms PO
3hrs later Misoprostol 200micrograms PO	6hrs later Misoprostol 200micrograms PO
3hrs later Misoprostol 200micrograms PO	6hrs later Misoprostol 200micrograms PO
3hrs later Misoprostol 200micrograms PO	6hrs later Misoprostol 200micrograms PO

- **34 weeks gestation and over**
- Administer Misoprostol 200 micrograms PV
- 3 hours later give Misoprostol 100 micrograms orally and continue 3 hourly to maximum of 4 further oral doses (total of 6 doses of Misoprostol).
- **In cases of previous uterine surgery (such as previous LSCS) or grand multiparous, the case must be discussed with the delivery suite**

Consultant. Give same Misoprostol doses and increase administration time to 6 hourly.

Unscarred Uterus	Scarred uterus/ grand multiparous
Mifepristone 200mg PO	Mifepristone 200mg PO
36-48hrs later Misoprostol 200micrograms PV	36-48hrs later Misoprostol 200micrograms PV
3hrs later Misoprostol 100micrograms PO	6hrs later Misoprostol 100micrograms PO
3hrs later Misoprostol 100micrograms PO	6hrs later Misoprostol 100micrograms PO
3hrs later Misoprostol 100micrograms PO	6hrs later Misoprostol 100micrograms PO
3hrs later Misoprostol 100micrograms PO	6hrs later Misoprostol 100micrograms PO
3hrs later Misoprostol 100micrograms PO	6hrs later Misoprostol 100micrograms PO

Misoprostol use may be associated with a transient rise in maternal temperature, however all temperatures must be investigated as per the sepsis pathway. Never assume a temperature is due to misoprostol use, and employ the sepsis six pathways as appropriate.

6.7 Actions Following Failed Induction of Labour with 1 course of Treatment

- Where birth is not achieved after the initial regime the Delivery Suite consultant should review the woman and a vaginal examination performed.
- If delivery is not achieved with the first regime then a period of **24 hours rest** is advised before a second round of treatment is considered (RCOG 2010)
- It may be that Oxytocin is indicated in the presence of ruptured membranes. This must be a Consultant decision and is dependent on gestation. The evidence suggests that this is most effective used only after **24 weeks gestation** (WHAT-TP-094).
- Any decisions on further treatment should be fully discussed with the women by the consultant in charge of Delivery Suite.

6.8 Intrapartum Care

6.8.1 Pain Relief

- If possible, pain relief options should be discussed prior to the onset of labour.
- All usual methods of pain relief are available to mothers unless contraindicated. Please avoid use of NSAIDs when Mifepristone has been administered. A platelet count will be required prior to epidural in cases of IUD, please have an early discussion with the anaesthetist regarding frequency of bloods required.
- In addition, women experiencing an IUD, termination or miscarriage can be offered intravenous opiate via a PCA pump. This is prescribed and set up by the anaesthetist on call.

6.8.2 Vaginal Examinations

- When **labour is established** vaginal examinations should be carried as per the 'Care in Labour Including Risk Assessment' guideline. They can be performed by the midwife regardless of gestation.
- If contractions have commenced but then stopped consider performing a vaginal examination to assess if the baby is in the vagina. This may be the case in early gestations

6.8.3 Fluid Balance

- The woman may eat and drink as normal whilst having misoprostol. Once labour is established, fluid balance, including guidance on eating and drinking and frequency in emptying the bladder will be monitored as per the Care of Women during Labour and Birth Guideline.
- This will be a high risk labour, please consider omeprazole prophylaxis [WAHT-TP-094].

6.8.4 Third Stage of Labour

- It is recommended that the third stage of labour is actively managed with oxytocics, regardless of gestation.
- The placenta, membranes and cord should be all examined and findings recorded in the electronic hospital records.
- **Placental swabs should be taken from the maternal and fetal side for all pregnancy losses**; this should be done as soon after delivery as possible.
- For guidance on management of retained placentas please refer to the 'Care in Labour Including Risk Assessment' guideline.
- Unless the parents decline, the placenta must be sent to histology for examination.
- The placenta must be placed into a plastic bag, the bag must be labelled. It is then placed into a plastic pot which must also be labelled (both the lid and the pot should be labelled in case of separation). A histology form must be completed and accompany the placenta as well as the 'clinical information for post-mortem' form, even if the baby is not having a post-mortem as it gives the pathologist more information, without these, it will not be examined..
- If the baby is having a post-mortem, the placenta can be sent together with the baby to the mortuary. If not then the placenta can go down to the lab to be sent to Birmingham before 12:00 Mon-Thurs. It should be stored in the fridge on Delivery Suite until it is sent and sent at the earliest convenience.
- If a mother wishes to take her placenta home please advise that she should take the placenta home as soon as possible. It should be packaged appropriately- into a sealed plastic bag, followed by an absorbent sheet and finally placed into further plastic bag due to potential leakage. This means that the placenta will not be examined by the Histopathologist, and the woman must be made aware of this.

- It is not recommended that women have their placenta's returned to them after it has been examined, due to the processes that the placenta has been through.

6.9 Inevitable Birth at Around 22 Weeks Gestation

- Where there is a very strong suspicion that a pregnancy is going to end below 22 weeks it may be appropriate for the women to be cared for in one of the Bereavement Suites.
- Where the gestation is over 22 weeks this may not be the case. Great care should be taken if considering using a bereavement suite for these women, many of the items have "in memory of" plaques on them, this could be greatly insensitive for a family who may not yet be aware their baby may die
- Parents should be counselled by senior paediatric registrar or consultant as per guideline for the management of preterm labour if delivery looks inevitable above 22 weeks.
- Where a woman is admitted to delivery suite with signs of preterm labour below 22 weeks it must be established if the baby is still alive. If so and delivery looks likely then it should be explained that there is a chance the baby will be born with signs of life.
- If time allows as much should be done to prepare the parents for this. The midwife needs to discuss the possibility that they may want to hold their baby and the senior paediatric registrar should be available to give a sensitive but honest explanation of why babies born alive at this gestation are not resuscitated.
- Although a baby born below 24 weeks with no signs of life is by medical terms a miscarriage, care should be taken to avoid using this term when talking to families. This is especially pertinent when it is known the baby is still alive prior to birth, and may actually be born with signs of life. This can cause confusion and distress for the family when the loss is then a neonatal death, and the birth and death need to be registered. A death certificate should be completed by a doctor but not issued to the parents until a referral has been made to the coroner and a decision made.
- When a baby is born alive below 22 weeks and, for the reasons above, is not actively resuscitated, parents should be sensitively informed that there are signs of life present as soon as they are noted. For example, the baby may make movements, the baby may gasp, or there may be heart beat noticed.
- A baby of any gestation who breathes or exhibits other signs of life, such as a heartbeat, pulsation of the cord, or definite movement of voluntary muscle, after expulsion from his or her mother, whether or not the cord has been cut or placenta is attached, is regarded as born alive (WHO 2012).
- It is very important the parents understand that the baby could not survive even with intensive care

6.10 Death Occurring on the Neonatal Intensive Care Unit (NICU)

- Where possible the baby should be nursed in a single room in NICU to allow privacy for the family

- When a baby is dying or dies on the NICU the family should have unlimited use of the Ben Bennet Suite with access to a named member of staff and refreshments. The woman may not be an inpatient at the time of the loss, so accommodation may be offered as it is important that the family have a base
- The family must always be part of the decision making process, as each family's requirements will differ.
- For information relating to baby's being blessed and baptised please contact the chaplaincy team, they can be reached 24 hours a day via switchboard.
- If the woman is an inpatient on the postnatal ward at the time of the death it may be an option to transfer her to one of the bereavement suites. This can provide privacy and alleviate any additional distress of being on a ward with other mothers.
- If the woman is an inpatient and it is known that her baby is dying or care is being withdrawn, it may be possible to transfer the baby to either the Ben Bennett Suite or one of the Bereavement Suites whilst the baby is still alive. This may allow for increased time spent as a family and improved privacy. Neonatal staff may need to be present or possibly be able to "come and go" as needed.
- On occasion it may be appropriate for the baby to be transferred out for hospice care this will be discussed with the family by the Neonatal unit and co-ordinated by them also. There are also cases where baby can be transferred home with support from the neonatal unit and outside agencies.

6.11 Termination of Pregnancy

- For all Rh –ve women who are having a termination of pregnancy, Anti D must be given with Mifepristone regardless of the FFDNA results. The Anti D will need to be repeated post-delivery following a kleihaur to exclude fetal-maternal haemorrhage during labour and delivery.

- **Before 21 weeks + 6days**
- The woman and her partner should be sensitively told that the baby may make movements at birth. This does not mean the baby will survive even with intensive care. The same information should be given as for a late miscarriage, see above section.
- The parents must be informed that the baby will need to be certified, and the parents must register it as a baby that has lived and died
- A referral will be made to the coroner if the baby is born with signs of life which will be managed by the bereavement team. This is very distressing for all concerned, therefore staff must be absolutely certain the baby has shown 'signs of life' as documented by the World Health Organisation (2012)

- **At, or after, 21 weeks + 6days**
- The RCOG (2010) recommends that for terminations at a gestational age of more than 21 weeks+6days, the method chosen should ensure that the fetus is not born alive. In these cases women will be offered feticide. This is undertaken within the fetal medicine department at BWH.

- When feticide is discussed, it is important the woman understands what is involved, where it is to be carried out and what she is likely to feel during the procedure.

6.12 Stillbirth or neonatal death outside the hospital

- For any stillbirth or early neonatal death outside hospital, it is optimal the woman and baby attend Delivery Suite for review and to get a clear understanding of events
- For neonatal deaths of a viable gestation, a paediatrician should examine the baby soon after arrival and commence the 'Sudden Unexplained Death in Childhood' (SUDIC) process and also alert the police (WHAT-CG-512). A coroner referral will need to be sent and the families should be kept informed of all the processes taking place whilst also supporting them in their grief.
- Parents should not be left unattended with their baby for any period of time.
- For stillbirths, a paediatrician should also examine the baby and depending on condition / history a decision should be made regarding the SUDIC process and coroner referral (a referral should always be made if there is any doubt whether or not the baby was born alive)

6.13 Care of the baby

- It should be explained to the woman what to expect at and following delivery. The woman/couple should be asked whether they would like to see the baby. Studies have shown that seeing and holding the baby facilitates an adequate grief response, with earlier acceptance. It is well established that 90% of couples accept an offer to see and hold the child and that no mother regrets the decision; many often speak fondly of the experience. However, the couple's wishes should be respected and if they choose not to see the baby, the option of taking photographs and/or foot/hand prints should be offered which can be kept in the medical records with their consent, if the couple wishes to view them at a later date.
- Parents often wish to know the sex of the baby for identity and naming. It may be difficult to tell the sex of the baby in the presence of dysmorphology. If there is any doubt, it is better to await the results of the post-mortem or karyotype (if performed). Wrong assignment of fetal sex can be very distressing. Below 20 weeks do not determine the gender of the baby; the parents may if they wish.
- The baby should be kept cold in the 'cold cot' or mortuary but NEVER IN THE FREEZER.
- Some parents may wish to take the baby home until the funeral or prior to return for post-mortem. There is no legal reason why they should not. For the protection of the parents and to avoid misunderstandings, staff should give them a completed "Parents taking baby home" form and 'Taking Your Baby Home' patient information leaflet (WHAT-PI-0847) to accompany the baby and a photocopy kept in the medical records (appendix 2 &3). The SANDS information leaflet needs to be provided to the parents for extra information. The police should be informed on 101 and a police log number documented.

- **Mementos & Photographs**

- Two sets of hand and footprints can be taken **with parental consent** and inserted in the memory box
- Families can also be offered a lock of hair from the baby, the towel the baby was wrapped in, clay hand and foot prints, foot casts (above 24/40), the cot card and duplicate name bands.
- After dressing the baby, with dignity, in their own clothes or clothes provided by delivery suite until own clothes available, photographs can be taken with the digital camera available on delivery suite with an individual memory card with the parents' consent.
- Other photographs can be taken using the digital cameras and individual memory cards provided these could include those with the parents holding the baby, and other family members as required.
- Parents can also take their own photographs with their own camera if they wish.
- All the mementos included in the booklet are offered to the parents. If they decline to accept the photographs or prints they should be stored in the patient's notes which will be transferred to a fire proof box in the Bereavement Midwives Office. Parents can collect this information at any time at a later date if they wish but should be encouraged to take them at the time. These could be put in a sealed envelope if the patients wish.
- For babies approximately over 24 weeks, depending on condition families can be offered the free service of 'Remember My Baby' professional photography.
- It is important all babies are labelled soon after delivery. Label with white labels or, in the event of the parents with different names, red and white labels, with parents' details. All babies should be labelled with their own label (If registerable) and with mums label and dads name (red label) if not married.
- If baby not registerable, please include two labels with mum's details and one label with dad's (if not married).

6.14 Certification

- A Midwife or doctor may complete both the medical certificate of stillbirth (under the desk on Delivery Suite) and the stillbirth certificate blue form, for cremation/burial. Neither of these needs to be signed by the parents. They should ideally be completed by those who attended the delivery
- Neonatal death certificates must be completed by medical staff. The doctor signing the forms should ideally have seen the baby both alive and to certify the death. Below 22/40 this should be an obstetric doctor, above 22 weeks, depending on the plan at delivery, it may be appropriate for the paediatrician to complete this. All professionals must sign and print their name clearly on the certificate with their professional qualifications and GMC number.
- Post mortem consent should be obtained by an obstetrician or midwife trained in gaining consent.
- All babies that require registration are issued with a hospital number and NHS number and in the case of live births also baby notes.
- All babies that show signs of life at delivery irrespective of gestation are registered as a live birth and issued with a hospital and an NHS number.

- In babies that are born with no signs of life up to 23+6 weeks gestation a burial or cremation form (purple form) is signed by both parents and the midwife and kept in the hospital notes for the bereavement team to forward to the bereavement office.
- For all gestations a 'Checklist for Parental Choices" must be completed by a midwife and left in the notes for the Bereavement Team to forward to the Bereavement Office.

6.15 Spiritual / pastoral support

- Support should be offered taking into consideration different faith, cultural and spiritual needs of the clients. *See Spiritual and Pastoral Care pages on A-Z pages of Trust Intranet.*
- Some couples may appreciate the option of having the baby blessed and named. Offer services of the hospital chaplain, their own minister or religious advisor. The chaplain can be contacted through switchboard (24 hours on-call chaplain service).
- The couple should be given information regarding the options for cremation or burial which can be organised by the hospital or some couples may wish to arrange the funeral themselves and the bereavement support midwife or chaplain can aid the couple in planning either of these.
- Leaflets regarding pastoral support are available in the bereavement packs.
- All professionals caring for bereaved parents should be aware of differing cultural requirements.
- An oak cabinet in the Alexandra Hospital Prayer Room contains a book of remembrance which recalls the names of babies and children who have died. The book is turned to display the correct date. Babies' names can be added via the chaplains. There is also a baby memorial garden at the Alexandra Hospital that provides a quiet sanctuary for bereaved parents. Babies' ashes can be scattered here – please contact the chaplains for more details.
- At WRH there is a Book of Remembrance kept in the entrance to the prayer room in which patients can make an entry if they wish.
- The Bereavement Garden at WRH is a place for quiet sanctuary only and not for ashes to be scattered

6.16 Post-mortem examination

- Seeking consent for post-mortem when the couple has just lost a child is difficult and can be distressing for all involved. Consent for post-mortem examination must be obtained from the parents, with the relevant explanation, information and discussion being provided by an obstetrician or Midwife who has been specifically trained, preferably someone who has been involved in her care. Use BWH Post-mortem Consent forms and the Parents Considering Giving Consent for a Post-Mortem, patient information leaflet (WAHT-PI-0559).
- Post-mortem examination can reveal valuable information which would help in the planning of future pregnancies. Evidence suggests that even when a likely prenatal diagnosis is reached, the post-mortem significantly changed the cause of death in 12% and found new information in 26% of cases.

- It is important to explain to the couple that the post-mortem will be performed by a dedicated perinatal pathologist, and that this therefore requires the baby being moved to another hospital in Birmingham. The baby is treated with dignity and respect at all times.
- The baby is returned once the post-mortem is complete. This may take up to 2 weeks.
- Parents should be informed of timescales for results which may take up to 12 weeks.
- They should be told what baby will look like on its return.
- If post-mortem was discussed/offered by a registrar and it is declined, the on-call consultant should be informed who may wish to discuss it further with the parents.
- If after further discussion the post-mortem is declined it should be clearly documented in the case notes.

- **What can be offered to parents who do not wish to have a post-mortem?**
- Consent for any of the following examinations should be obtained from the parents with the relevant explanation, information and discussion being provided by an experienced obstetric Registrar or a Consultant.

- **Fetal imaging:** In cases where a genetic syndrome is suspected and the parents decline a post-mortem, they may accept fetal imaging with MRI or skeletal X-rays; in some cases, a geneticist may be able to examine the baby externally for dysmorphic features. This can only be done at BWH and not at WRH.

- **Placental Histology & Cytogenetics:** Couples usually consent to histological examinations of the placenta which often offers valuable information on inflammatory or infective causes. Placental abnormalities may be associated with fetal demise. Placental tissue can also be sent for karyotyping and cytogenetics it is important to ensure it is in dry pot with **no formalin.**

- **Skin biopsy:** Sterile urine bottle, with sterile transport medium. As it is critical to keep the biopsy moist if the medium is unavailable, use sterile saline. Do not use iodine or betadine to clean biopsy site. Alcohol, Phisoderm or a similar product is acceptable. Excise biopsy with sterile forceps and blade. Immediately place the biopsy carefully into the collection container with the medium and close the container. Label the container with the location of the skin biopsy/biopsies (if more than one, please keep in separate containers and label which one is from which site), patient name, date, and time. Keep container at room temperature and send as soon as possible to the laboratory.

6.17 Transfer to the mortuary

- A member of the portering staff and clinical staff (midwife or nurse) will escort the porter over the mortuary with the baby in a pram.
- At WRH the check books should be signed on delivery suite by the Porter and the Midwifery staff to register the whereabouts of the baby and any

accompanying property. The porters are given a receipt, which is filed in the bereavement office.

- All babies are wrapped and the portering staff will arrive with the pram to go back over to the mortuary. If there is to be a post-mortem the placenta should accompany the baby to the mortuary in a labelled dry pot as well as the relevant paperwork and consent forms. If there is no post mortem the placenta stays on delivery suite in the fridge in a dry pot. This needs to be taken to Pathology reception to go to Birmingham Women's Hospital Mortuary via the daily transport (the placenta needs to be in the lab before midday Monday to Thursday).
- Please note, if the baby is classed as a high infection risk or if the baby is of a mother who is high infection risk then the baby needs to be placed in a marked body bag on Delivery Suite or the Birth Centre. The bags are available from the bereavement cupboard, located outside Snowdrop Suite.
- Tissue samples for cytogenetics, having been stored in the correct medium and container, should then be placed in a white bucket, correctly labelled, and kept in the fridge on delivery suite to be collected in the same way as the placentas. If the baby's parents have different surnames, the baby is labelled with the mother's details on a white label and the father's details on a red label.
- On arrival to the mortuary, details must be entered in the register. The register logging in process should include details of both the fetus or the baby and the placenta, this will be done by the portering staff and midwifery staff do not need to go past the first reception room.
- The register details must include the name of the fetus or the baby, with the date and time of admission into the mortuary

6.18 Suppression of Lactation

- All women should be offered the chance to discuss lactation after a pregnancy loss; this is regardless of gestation or parity. Whilst many will find the production of milk an extremely distressing experience following the loss of their baby it should never be assumed that this is the case, the options should always be discussed.
- Carbergoline prevents the production of prolactin and therefore can suppress lactation. The use of Carbergoline is contraindicated in women with pre-eclampsia, hypertension, cardiac valvulopathy, and some fibrotic conditions. In the absence of this 1mg can be prescribed by medical staff, it is a stock item on delivery suite. By the second week following birth Carbergoline has no superiority over non pharmacological methods. (Tchoffo PA 2009)
- For all women regardless of whether they cannot have, or choose not to have Carbergoline the following self-help advice should be given;
    - wear a supportive but not tight fitting bra or crop top day and night
    - avoid any stimulation of the breast or expressing milk if possible, this may prolong lactation
    - Breast pads may be needed
    - Cold compresses and analgesia can be used for discomfort
- Advice should be given on the physical signs of mastitis, women should contact their GP or midwife if they occur.

- For mothers from the NICU who have been expressing milk or breast feeding, it would be advisable to gradually reduce this as stopping abruptly may cause additional discomfort. The amount of expressing and milk produced will determine how quickly this can happen.

6.19 Support for Families

- All families should be provided with information on how to access the bereavement team, and what support is offered.
- They should know how to arrange an appointment to come back and see their baby should they wish
- Information can be sourced and provided to all women experiencing bereavement. This may include;
    - Available financial help, including maternity benefits
    - Exercise and advice leaflets,
    - Help for bereaved parents booklet
    - Funeral options
    - Information regarding post-mortem consent
    - Support groups
    - 'Saying Goodbye to Your Baby' booklet by Sands
- It is important to note that a small number of women their partners and possibly other family members may want at some stage to see a professional counsellor. A counsellor has a relationship that is different and preferably separate from the parent's relationship with other members of staff. The Bereavement team can sign post families to support that is local to them such as.
- South Worcestershire Bereavement Support Tel helpline: 01905 760934 (available for those women registered with a GP in Martley, Evesham, Worcester, Great Malvern, Droitwich, Pershore). www.bereavementsupportworcestershire.org.uk
- Miscarriage Association, Tel. No. 01924 200799, Monday – Friday 9.00 a.m. – 4.00 p.m.
- SANDS (Stillbirth & Neonatal Death Society) Tel. No. 0207436 7940 Monday – Friday 10.00 a.m. – 3.00 p.m.
- Cedar Tree (Miscarriage/Stillbirth Counselling/Support) Tel. No. 01905 616166

6.20 Discharge to Community

- When women are discharged to community, an electronic discharge summary (EDS) should be completed and attached to the PN clipboard. Information must be documented on here with a plan for follow up. For example if the community midwife needs to call or visit and when.
- Please ensure a medical discharge is completed by a doctor prior to discharge
- The bereavement team will always call the following day (Mon-Fri) but will not often visit the first day home so please ensure a CMW visit is requested if required.

6.21 Follow up Appointments

- All women should be offered a follow up appointment when the results of investigations are reported; the bereavement team will keep in communication with the families to keep them informed of expected timescales of this appointment. This appointment will be with a member of the bereavement team as well as their named consultant.
- Some couples will have appointments with both obstetric and paediatric staff. Couples where the baby has had care from the NICU will be offered the opportunity to have an appointment with their baby's consultant paediatrician.
- For all late miscarriages, stillbirths and premature births leading to neonatal death the opportunity to have specialist pregnancy loss bloods will be offered at around eight weeks post-delivery.
- If an investigation is positive, discuss management in future pregnancies and recurrence risks.
- If no cause is found, a clear plan for the next pregnancy should be laid out.
- Specific behaviours such as folic acid supplementation, smoking cessation, weight loss and adequate blood glucose control in diabetics should be considered.
- Clear documentation, including a letter to GP, should be prepared.
- It may be helpful to write to the parents to summarise findings and management in future pregnancies, in case they chose to book elsewhere in future pregnancies.
- The couple should be offered a further appointment to discuss certain aspects, or a pre-conceptual visit.

6.22 Staff support

- All staff need an open and supportive environment in which the stress and difficulty of caring for families who have experienced the loss of their baby are acknowledged.
- Staff should feel able to share their concerns, anxieties and worries.
- Midwives have access to their PMA's for additional support where required
- Managers have a particular duty to provide encouragement and support to those caring for bereaved families
- All staff can access support through their line managers, PMA's, the chaplaincy team and through occupational health

6.23 Documentation

- All documentation must be completed in keeping with the NMC guidance on record keeping (2015).
- Accurate documentation of events can be essential when debriefing a family and help with investigations into the cause of the loss.
- A bereavement checklist (appendix 4) should be commenced as soon as the death is known about.

- Bereavement checklists are kept within the packs on Delivery Suite and should be contemporaneously filled in
- Birth notifications and an NHS number are required for all live births and stillbirths.
- It is the responsibility of the midwife present at the birth to input the data correctly and ensure accuracy as errors can further upset parents
- You should complete the neonatal record, including the birth details on all babies, including weight for all live births irrespective of gestation or length of time alive.

6.24 DATIX and Duty of Candour

- A DATIX must be completed for all pregnancy losses after 22 weeks gestation
- A Duty of Candour leaflet must be given to families if concerns have been raised on the quality of care received
- An Initial Case Review (ICR) should be completed within 72hrs of the incident by a nominated member of the Women and Children's team.
- The Bereavement Team will discuss with families any standardised reviews of their care that will take place, such as the Perinatal Mortality Review Tool (PMRT), Health and Safety Investigation Board (HSIB) or a Coroner investigation
- Families feedback will be gathered by the Bereavement Team to be fed into the review

Appendices

1. Bereavement Support Following the Death of Your Baby
2. Taking Your Baby Home leaflet
3. Parents taking baby home form
4. Bereavement Checklist
5. What to Expect When coming in for Medical Management of Induction of Labour


Bereavement support following the death of your baby
Worcestershire
Acute Hospitals NHS Trust

Appendix 2 Taking you baby home from hospital

Appendix 3 Parents taking baby home form

Worcestershire Acute Hospitals NHS Trust

Parents taking baby home from hospital

I/we (name/s) _____ wish to take the body of my/our baby (name)_____ home from Worcestershire Royal Hospital.

I/we accept that it is our responsibility to register the birth/death if required and to contact a funeral director or cemetery to arrange for a funeral as soon as possible.

If I/we choose to make alternative funeral arrangements I/we understand that I/we need to contact the Department of Environmental Health for advice.

Parents

Signed_____ Print name_____

Signed_____ Print name_____

Witnessed by staff

Signed_____ Print name_____

Police log number _____

1 copy for parents and 1 copy for the Bereavement Office

Appendix 4 Bereavement Checklist

Obstetric Pathways
WAHT-TP-094

APPENDIX C

CHECK LIST FOLLOWING PREGNANCY LOSS

Baby	Parents
Name:	Mother's Name:
Unit No: Weight: Centile:	Mother's Unit No:
NHS No:	Father's Name:
Date and time of delivery:	Tel No:

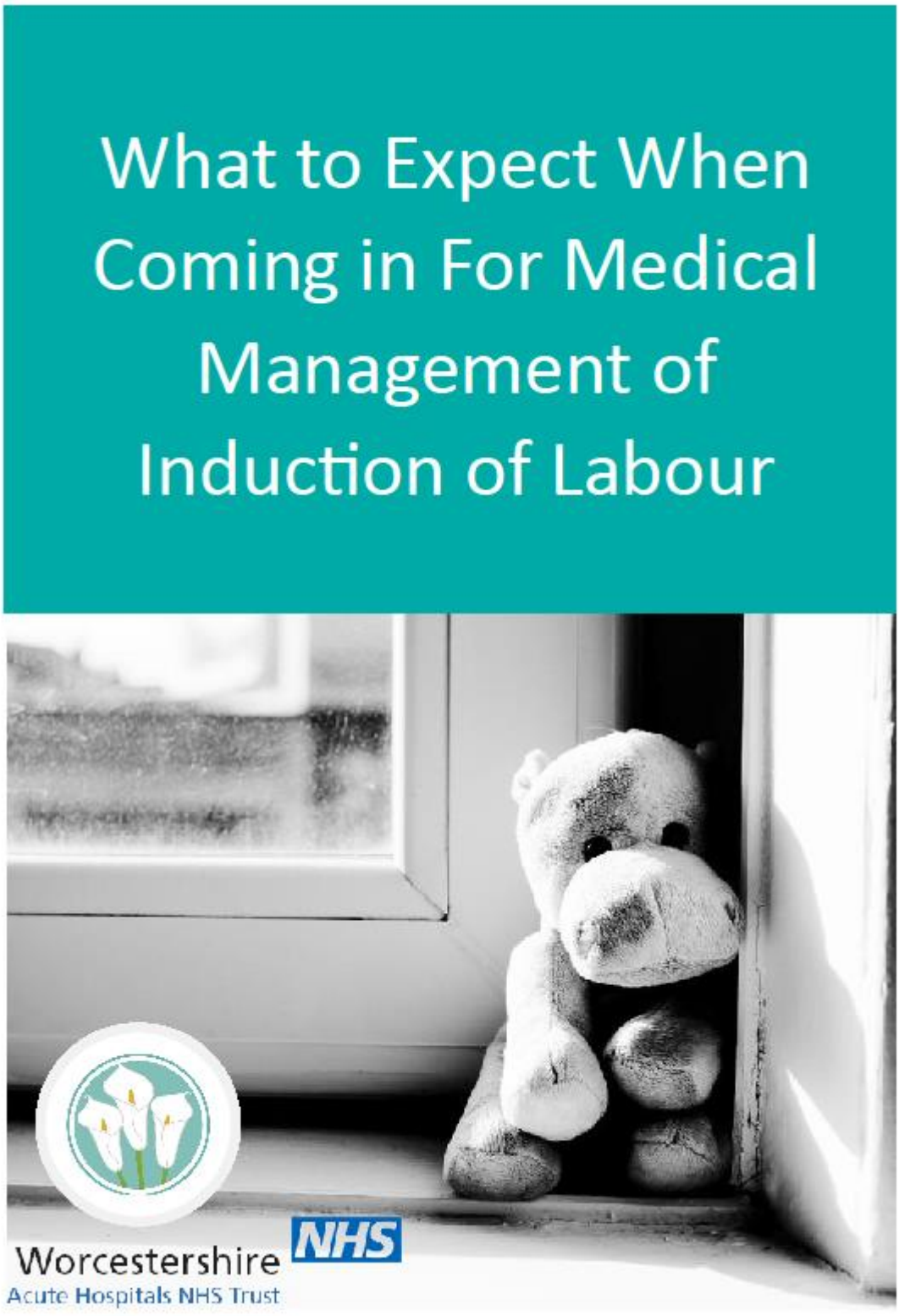
	Please tick, sign and date
1. Both parents informed of pregnancy loss	☐
2. Named Consultant Obstetrician informed ☐ Manager on call ☐ On-call Consultant informed ☐ Bereavement Support Midwife ☐	Named Consultant: Manager on call: On-call Consultant:
3.Give patient information leaflet 'Bereavement Support Following the Death of Your Baby' or/and 'SANDS Bereavement Support Book'	
4. Written consented gained prior to commencing Mife / Miso for induction process or TOP (If TOP, 'Abortion Form' must also be signed by 2 doctors).	
5.Bloods and swabs to be taken if applicable can be requested on ICE via the following route Log on to ICE ↓ Identify woman, ↓ Requesting ↓ Specialities ↓ Obs &Gynae ↓ Profiles ↓ Intra Uterine Death (Blood Cultures only if pyrexial)	Blood packs in bereavement cupboard with help guide.
6. Parents given the opportunity to see and cuddle baby	☐
7. Birth Register & Birth Notification completed if applicable (over 24/40 and including any baby born at any gestation showing signs of life.)	☐
8. Neonatal Record completed if applicable (Live birth)	☐

9. Mementos:-	Taken	Kept in notes	Given to parent	Offer parents the choice twice if they decline the first time.
Photographs/ Digital Memory Card				
Cot Card				
Foot/Hand Prints				
Clay Hand/Foot Impressions				
Clay hand/foot prints sent to BWH if baby having PM *labelled with mums addressograph label*	Yes / No			
Memory Box				

Page **1** of **3**

This information should be used in conjunction with the Obstetric Pathways – WAHT-TP-094. Use the version on the internet to ensure the most up to date information is being used. **Jan 2018**

Appendix 5 What to Expect When coming in for Medical Management of Induction of Labour



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Contribution List

This key document has been circulated to the following individuals for consultation;

Designation

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race		
	Ethnic origins (including gypsies and travellers)		
	Nationality		
	Gender		
	Culture		
	Religion or belief		
	Sexual orientation including lesbian, gay and bisexual people		
	Age		
2.	**Is there any evidence that some groups are affected differently?**		
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**		
4.	**Is the impact of the policy/guidance likely to be negative?**		
5.	**If so can the impact be avoided?**		
6.	**What alternatives are there to achieving the policy/guidance without the impact?**		
7.	**Can we reduce the impact by taking different action?**		

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.