Clinical guideline for the Management of Stillbirth, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 24+0 weeks gestation

Author/Owner	**Bereavement Midwife**	
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1.0 Introduction

In 2018, approximately 1 in 263 babies in England were stillborn (3.8 per 1000). Although a welcome reduction from the previous year (1.2), the UK continues to have an above average rate of stillbirth when compared to other high-income countries.

For the purpose of this guideline, types of loss from 24+0 weeks gestation and are defined as:

- Stillbirth/Intrauterine fetal death (IUFD)
- Medical Termination of Pregnancy (MTOP) for fetal abnormalities

Early Neonatal Death (live birth ending in death)

Definitions

An **IUFD after 24+0** weeks gestation is classed as a **stillbirth**. The definition of "stillborn child" in England and Wales is contained in the Births and Deaths Registration Act 1953 section 41 as amended by the Stillbirth (Definition) Act 1992 section 1(1) and is as follows:

"a child which has issued forth from its mother after the twenty-fourth week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life, " (1)

When signs of life are recognised at birth, at ANY gestation (including babies born as the result of MTOP), the subsequent death, must be managed as an **Early Neonatal Death** (A neonatal death is defined as a baby born showing signs of life, at ANY gestation during pregnancy, which dies within 28 days of being born); care should be adapted appropriately and all documentation should be completed in line with local guidance and legal requirements.

Occasionally, medical termination of pregnancy (MTOP) for fetal abnormalities may be required to be performed after 24 weeks gestation. Termination of pregnancy is legal at any gestation following a diagnosis of a severe abnormality. The RCOG recommends that "for all terminations at gestational age of more than 21+6 weeks, the method chosen should ensure that the fetus is born dead" (2).

2.0 Objective

The purpose of this guideline is to support obstetric and maternity staff to deliver gold standard care in the management of women experiencing a second trimester pregnancy/neonatal loss, from 24+0 weeks gestation.

3.0 Scope

This guideline applies to all medical and midwifery staff working in maternity services. It should be used for all types of pregnancy loss from 24+0 weeks gestation in conjunction with the Management of Stillbirth/neonatal death Care Pathway.

Separate guidelines are available to care for women experiencing earlier pregnancy loss:

- Clinical guideline for the Management of Late Miscarriage, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 20+0 to 23+6 weeks gestation.

Standard Operating Procedures (SOPs) are available to support this guideline:

- **SOP for the care, storage and transfer of a fetus or stillborn baby (Use of the Baby Refrigeration Cabinet and CuddleCot™)** Care Storage And Transfer Of A Fetus Or Stillborn Baby
- **SOP for supporting parents who wish to take their stillborn baby home** (awaiting JB review 19/04/2022)

4.0 Care of bereaved parents

The Ockenden report (2022) highlights that healthcare professionals must be deliver "Compassionate, individualised, high quality bereavement care for all families who have experienced a perinatal loss" (3)

In the event of any late pregnancy loss, the news can come as a complete shock to the parents; they deserve to be cared for with empathy and compassion. Many parents are surprised that they will have to go through labour; shocked that there may be a delay in giving birth; and anxious that the delay may possibly mean there is an option to go home whilst awaiting the birth of their baby who has died. It is vital that they are fully informed. Questions should be welcomed and encouraged, and discussions should aim to support parental choice.

Commenting about mid-trimester loss a Sands report claims:

"No level of care can take away the pain and grief families feel, but high quality care can have a huge impact on their wellbeing, help them to process their grief and begin to learn to live without their much-loved baby, in the short-term and for the rest of their lives." (4)

Parents need sensitive, non-judgmental and empathetic care and should be cared for with compassion Healthcare professionals should be aware of what the hospital can offer and allow time for parents to make decisions and decide what is right for them. Parents should be offered choices and support around bereavement care, including time and privacy with their baby, opportunities to make memories and discussion around post mortem and funeral options. The individual needs of the woman and (where appropriate) her partner should be central to the provision of care and any communication with them. Health care professionals should actively listen and take the lead from the woman and her partner regarding preferred terminology. It is important that healthcare professionals are sensitive to the responses and needs of parents from different cultural backgrounds and religious groups. However, it is vital

that healthcare professionals do not make assumptions concerning culture, and approach each parent as an individual needing support at an extremely difficult time. Parents may want the opportunity to see their own religious leader or a member of the hospital chaplaincy service. This should be facilitated by the maternity unit staff via switchboard. The chaplaincy service is available 24 hours a day, 7 days a week.

The preferences of bereaved families should be sought and all bereaved parents must be offered informed choices about decisions relating to their care and the care of their babies. A parent-led bereavement care plan should be in place, providing continuity between settings and into any subsequent pregnancies. The National Bereavement Care Pathway's (NBCP) for Stillbirth, MTOP and neonatal death provide dedicated, evidence-based guidance for professionals delivering bereavement care to parents and families (5) NBCP pathways material | National Bereavement Care Pathway (NBCP) (nbcpathway.org.uk)
The death of a baby can be associated with short and long term anxiety and depression, not only in mothers but also partners and other family members. It is important to ensure that the family are well supported throughout the hospital stay and beyond, with as much continuity of care as possible. Every woman who has an IUFD is at risk of depression, but those with a previous psychiatric disease or of a vulnerable social group are at particular risk.

5.0 Main body of the document

5.1 Diagnosis of IUFD and immediate care

A thorough clinical history and physical examination are important in the assessment of women presenting with symptoms or signs suggestive of any type late pregnancy or neonatal loss.

Care should be provided in line with the guideline for Admission to the maternity assessment unit v2.pdf (trent.nhs.uk)

The optimal method of diagnosis of an intrauterine fetal death (IUFD) is a 2-dimensional ultrasound scan. The scan should be performed at the earliest opportunity, by an experienced and suitably trained clinician (a Sonographer or an Obstetrician). Auscultation and cardiotocography should not be used to investigate suspected IUFD. If the diagnosis is suspected in the community setting, then the woman should be referred to hospital for confirmation.

It is advisable to obtain a second opinion from a suitably trained person whenever possible, although it is recognised that this may not always be possible in emergency situations.
Following the diagnosis and confirmation of an IUFD the parents must be given time to absorb and accept the news. A clear, sensitive and honest explanation should be given by experienced staff. The language used should be clear. Below is an example statement:

"I'm terribly sorry, I can see your baby's heart and it is not beating. I am sorry, this means your baby has died."

If the woman has attended on her own, unless it is an emergency, it may be prudent to delay detailed explanation before support has arrived. An immediate offer to contact her partner or a family member or friend must be made, and support given.

Parents should be offered the use of the bereavement suite throughout the admission. For the purpose of clinical care and during labour/birth it may be necessary to transfer the patient to a room with appropriate facilities on the Birthing Centre. The partner/family may remain with the mother as long as she wishes.

When an IUFD has been confirmed, the possibility of passive fetal movements should be discussed with the woman. It should be explained that she may still feel the baby move inside the uterus as it floats around in the amniotic fluid; mistaking this sensation for the feelings of active physical movements of the baby can be very distressing for the mother if she is not prepared for it.

Although care should be taken not to overload the parents with too much detail initially, it is important to give adequate information. The trust Information for Parents Following Bereavement; Leaflet 1, should be offered: “When Your Baby Dies, - Preparing for birth, meeting your baby & creating memories”. **See Appendix 1.**

Parents should be included in discussions about management options and their wishes should be considered. Some mothers will want to go home and see family members before delivery whilst others will want the induction process to commence as soon as possible.

Staff should use a Maternity Bereavement Pack to guide care from the point a pregnancy loss is diagnosed, or when MTOP care is commenced. The pack includes all relevant documentation and checklists required to provide care for bereaved families.

See **Appendix 8** for the checklist for IUFD/MTOP) and **Appendix 9** for the checklist for Neonatal Deaths.

The woman should be given a 24-hour contact number if she goes home.

5.2 Stillbirth and Neonatal Death in Multiple Pregnancy

Multiples make up approximately 3% of pregnancies in the UK with numbers rising significantly over the past 20 years due to the increasing use of assisted conception techniques such as IVF.

Clinicians should be aware that intrauterine fetal death occurs more frequently in multiple pregnancies than singleton pregnancies. According to the MBRRACE-UK Perinatal Mortality Surveillance Report for Births 2019, women expecting twins were 2.2 times more likely to experience stillbirth than women expecting singletons (6)

Clinicians should appreciate the complexity and mixed emotions of couples who experience miscarriage, termination or selective reduction of one fetus with a surviving twin or higher order multiple. They will require the same support through delivery and bereavement care. Parents may want to talk about the baby that has died and to acknowledge that they were twins. Some parents may wish to take photographs of the babies together so this should be discussed and offered.

The timing and mode of delivery for multiple pregnancies in the case of single fetal demise will depend on chorionicity, gestation, the position of the fetuses and the wellbeing of the surviving baby/babies. Specialist advice should be sought in complex cases from the local multiple pregnancy lead.

5.3 Clinical investigation of the cause of IUFD

After diagnosis of an IUFD, clinical assessment and laboratory tests should be recommended to assess maternal wellbeing and to determine the possible cause of fetal death, the chance of recurrence and possible means of avoiding further pregnancy complications.

See **Appendix 2**, for a table of recommended tests and investigations at the point of diagnosis of an IUFD.

5.4 Birth at the Threshold of Viability (when IUFD has not been confirmed)

In the event that a mother is likely to give birth at the threshold of viability in instances where an IUFD has not been confirmed and there is the possibility of an extreme premature live birth, caregivers should refer to the local preterm labour guideline and the British Association of Perinatal Medicine (BAPM) Framework for Practice for The Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation, (7). https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019

The framework states that a key ethical consideration for decisions about instituting life-sustaining treatment for an extremely preterm baby is the baby's prognosis – the risk of an acceptable (or unacceptable) outcome if active (survival focused) management is undertaken. If there is a plan to provide life-sustaining treatment for the baby, then it follows that the pregnancy and birth should be managed with the aim of optimising the baby's condition at birth and subsequently.

BAPM advise a stepwise approach to decision-making, involving three key stages:

1. Assessment of the risk for the baby if delivery occurs, incorporating both gestational age and factors affecting fetal and/or maternal health.
2. Counselling parents, and their involvement in decision-making.
3. Agreeing and communicating a management plan (7)

5.5 Care following late medical termination of pregnancy (MTOP) >24 weeks gestation

The RCOG recommends that "for all terminations at gestational age of more than 21+6 weeks, the method chosen should ensure that the fetus is born dead" (2). MTOP at this late gestation requires a feticide procedure, prior to induction of labour. Women are referred to a local tertiary centre for feticide to be performed, they then return to the local unit for induction after the procedure has been performed.

The feticide procedure is performed under ultrasound control with 15% KCl solution injected into either the umbilical cord vein or heart. A further ultrasound scan is performed 30 minutes after the procedure to ensure fetal demise. In certain specific situations where the fetus would die in the immediate neonatal period from the abnormality e.g. anencephaly, limb body wall complex, bilateral renal agenesis and lethal skeletal dysplasia's, feticide is not a legal requirement (2).

The timing of termination medication will need to be agreed with the tertiary centre performing the feticide. In general mifepristone 200mg could be given 48 hours prior to the procedure, however, if there is a high risk that labour will follow administration of mifepristone, e.g. if there is spontaneous rupture of the membranes, polyhydramnios or the pregnancy is near term / >34 weeks then this should be given after the feticide.

5.6 Induction of labour for Medical Termination of Pregnancy (MTOP)

Guidance for the process of induction of labour in cases of MTOP involves Pre-induction and induction treatment as detailed above for the management of IUFD, See **Appendix 4** for MTOP induction of labour drug regime.

5.7 Labour & Birth for Women with Confirmed IUFD

Vaginal birth is the recommended mode of delivery for most women with an IUFD, but caesarean birth should be considered for some women; based on their preferences, previous intrapartum history and medical condition.

Women experiencing a stillbirth will be deemed as high risk; the most appropriate place for care during labour and birth is likely to be the Birthing Centre under shared care of Midwives and the Obstetric team.

A risk assessment should be completed in the stillbirth care pathway with consideration given to underlying medical or obstetric conditions and the potential risk of sepsis.
If there is sepsis, abruption/antepartum haemorrhage (APH) and/or severe pre-eclampsia, the method of delivery and/or induction of labour should be customised to the presenting condition and other patient factors including past obstetric and past medical history.

If the above have been excluded, then timing and the process of birth can be discussed with the mother by a senior clinician. Over 85% of women with a confirmed IUFD will spontaneously deliver within 3 weeks (2). The mother should be offered a choice of induction of labour or expectant management. If she chooses the latter option, then arrangements for review will need to be made. In the majority of cases of singleton IUFD, parents opt to induce labour to expedite delivery. Parents should be included in discussions and given informed choice regarding management.

Caesarean birth may occasionally be clinically indicated by virtue of maternal condition. The woman herself may request caesarean section because of previous experiences or a wish to avoid vaginal birth of a dead baby. This demands a careful and sensitive discussion and joint decision making. The implications of caesarean delivery for future childbearing should be discussed (2).

Care during labour and birth should be documented in detail in the fetal loss care pathway/partogram.

5.8 Expectant Management of Labour

Women with a confirmed IUFD, who are not in active labour and have no evidence of sepsis, pre-eclampsia, placental abruption/antepartum haemorrhage or membrane rupture, may choose expectant management.

Well women with intact membranes and no laboratory evidence of disseminated intravascular coagulopathy (DIC) should be advised that they are unlikely to come to physical harm if they delay labour for a short period.

Women contemplating prolonged expectant management should be advised that the value of post-mortem may be reduced, and that the appearance of the baby may deteriorate.
There is a 10% chance of maternal DIC within four weeks from the date of fetal death and an increasing chance thereafter (2). It should be noted that it is not usually possible to determine the exact date of the death. Women who delay labour for periods longer than 48 hours should be advised to have testing for DIC twice weekly.

Women who are managed as an outpatient should be given a 24-hour contact number for any time between diagnosis and delivery.

See **Appendix 3,** for the table of tests required for women choosing expectant management.

5.9 Active Management of Labour

- In about 90% of cases, vaginal birth can be achieved within 24 hours of induction of labour for women with an IUFD,. Vaginal birth carries the potential advantages of immediate recovery and quicker return home.
- A combination of Mifepristone and Misoprostol should usually be recommended as the first-line intervention for induction of labour. Women with a favourable cervix or in early labour, may be offered amniotomy followed by oxytocin infusion.
- Urgent delivery is required if there is sepsis, abruption/antepartum haemorrhage (APH), or severe pre-eclampsia.
- In the case of previous caesarean section, a discussion of the safety and benefits of induction of labour should be undertaken by a consultant obstetrician, and the dosage and administration of Misoprostol should be discussed. Mifepristone can be used alone to increase the chance of labour significantly within 72 hours (avoiding the use of prostaglandin). See **Appendix 4**.
    - Women with a single lower segment scar and IUFD should be advised that induction of labour with prostaglandin is safe but not without risk
    - Women with two previous caesarean sections should be advised that the risk of induction with Misoprostol is only slightly higher than that of women with one previous scar
    - Women with more than 2 caesarean sections or an atypical scar (for example classical caesarean section, inverted T incision and previous myomectomy with breaching of the uterine cavity) should be advised that the safety of induction is unknown (2)

5.9a Stage One of Treatment- Pre-induction for all women with scarred or unscarred uterus

- Mifepristone is a steroidal drug which is taken orally, it sensitises the uterine wall to prostaglandin-induced contractions, and ripens the cervix
- Mifepristone is a recorded drug, its administration should be recorded in the controlled drug book
- Mifepristone should only be administered within the maternity unit and the woman should be observed when taking this medication
- The woman should remain in the unit for 1 hour following administration to ensure she is not affected by nausea or vomiting (If the woman vomits within 60 minutes, the treatment will need to be repeated).
- If the woman has an unscarred uterus and remains well, she will be given the option to go home and return for stage two of treatment between 36-48 hours later
- The woman should be given a date and time to return to the Birthing Centre and a 24-hour contact number for any time between diagnosis and delivery
- The woman should be advised to contact the Birthing centre if she experiences any of the following symptoms:
  - Pyrexia
  - Tachycardia
  - Vaginal bleeding
  - Abdominal pain/contractions
  - Spontaneous rupture of membranes
  - Any other symptoms of deteriorating health

See **Appendix 4** for stage one of treatment: Active management of labour - drug regime information.

5.9b Stage Two of Treatment- Active Management of Labour for women with an unscarred uterus (no history of caesarean section)

- During readmission for labour care, the Trust Information for Parents Following Bereavement; Leaflet 2, should be offered: “When Your Baby Dies: Birth Registration, Funeral Arrangements & Options for post mortem examination”. **See Appendix 1**
- On return to the unit the women should have baseline observations recorded and other tests/samples should be obtained as detailed in **Appendix 2**
- Misoprostol is a synthetic prostaglandin which acts as a uterine stimulant. Dosage will depend on the gestation at which the IUFD occurred (see **appendix 4**).
- Women experiencing regular contractions should NOT be given Misoprostol; they should be reviewed after 2 hours, and a decision should be made with regards to administering misoprostol

Stage two of treatment: Active management of labour drug regime information; see **Appendix 4.**

5.9c Stage Two of Treatment- Active Management of Labour for women with an scarred uterus (history of caesarean section or atypical uterine scars)

There is an increased risk, between 3% and 12%, of uterine rupture in women with IUFD who have had previous caesarean section (2). Discussion about safety and benefits of induction of labour should be undertaken by a Consultant Obstetrician.

One previous lower segment caesarean section (LSCS).

- If the cervix is favourable, then induction by amniotomy and oxytocin can be used – discuss with Consultant on call.

- Women with an unfavorable cervix:
    - Mifepristone 600 milligrams should be given on 2 consecutive days, 24 hours apart. The woman should be advised to remain in hospital during this time. On day 3, a cervical ripening balloon should be offered (2)
    - Misoprostol may be considered but with doses not yet marketed in the UK (2).If not effective after a course of 5 doses, discuss with Consultant consider repeat misoprostol at least 12 hours after the last dose.

Two or more lower segment caesarean sections or atypical scars

- The absolute risk of uterine rupture after two or more caesarean sections or with atypical scars is unknown, however it can be stated to be higher than that of only one previous LSCS.
- Women with two or more previous LSCS should be advised that the safety of induction of labour with prostaglandin is unknown, therefore a cervical ripening balloon may be associated with lower risk and should be considered (2). This is associated with a lower hyper stimulation rate, and higher maternal satisfaction. The uterine rupture rate is similar to that which occurs with spontaneous labour.
- The regime in **Appendix 4** may be used but mode of delivery should be discussed with a Consultant Obstetrician on an individual basis.

See **Appendix 4,** for Stage two of treatment: Active management of labour drug regime information.

5.10 Care in labour

- Women should be admitted to the bereavement suite with access to an appropriate delivery room to ensure that her emotional and practical needs can be met without compromising safety
- Care in labour should be provided by an experienced midwife and the woman's birth choices should be supported as for any labouring woman
- Obstetric staff should be vigilant to clinical features that may suggest uterine scar dehiscence/rupture: tachycardia, atypical pain, vaginal bleeding, haematuria and maternal collapse.
- The care pathway for fetal loss after 20 weeks gestation should be completed in all cases of stillbirth
- The partogram within the care pathway for fetal loss after 20 weeks gestation should be completed in all cases of labour of an IUFD so that clinical trends and complications may be identified
- Adequate analgesia should be provided, and all modalities should be made available including regional analgesia and patient controlled analgesia

- Women with IUFD and Group B Streptococcal (GBS) colonisation do not require antibiotic prophylaxis in labour

5.11 Management of the 3rd stage of labour following stillbirth

The third stage of labour can be managed by continuing the Misoprostol regime. Consideration may be given for the administration of oxytocin in line with local normal delivery guidance.

5.12 Postnatal Care of the Mother and the Stillborn

- The individual needs of each family should be identified and accommodated. Assistance should be given to facilitate the grieving process including empathetic care, appropriate literature and contact telephone numbers
- Seeing and spending time with baby is valuable for parents. It may be necessary to prepare them about their baby's appearance. Some parents may wish to see and hold their baby immediately after the birth, others may prefer to wait. Either way their decision should be respected and supported
- Parents should be offered the use of the cooling cot to maintain the condition of the baby. The cooling cot can improve the quality of bereavement care as it allows parents to spend more time with their baby and enhances their lasting memories. See Standard operating procedure for the care, storage and transfer of a fetus or stillborn baby
- An external examination of the baby should be performed by the midwife and in cases of difficulty or suspected abnormality should be confirmed by a paediatrician
- The baby should be weighed
    - The birth weight should always be entered into the GROW database in order to generate a birth weight centile to identify if the baby was small for gestational age or normal weight.
    - For details of the tests required to be performed on baby/placenta; **See Appendix 5**.
- The baby should be labelled, details should include:
    - Baby's name
    - Date and time of birth
    - Mothers FULL name
- Parents may be encouraged to choose clothes for their baby and supported to dress him/her
- Parents should be offered and supported with opportunities to create lasting memories with their baby and should be offered mementos to keep
  See Appendix 6 for a full list of keepsakes and memory making options.

- Suppression of lactation should be discussed with the woman. Cabergoline 1mg may be administered orally, unless there is maternal hypertension/pre-eclampsia or puerperal psychosis

- Thromboprophylaxis risk assessment should be performed as stillbirth increases the risk of venous thromboembolism

5.13 Clinical Investigations after Stillbirth or Early Neonatal Death

There are several reasons why investigations into an IUFD are important:

- Parents may find out the cause of death which can help with the grieving process
- Useful information may come to light which could be significant in planning future pregnancies
- For research purposes, to prevent stillbirths in future

Even with full investigation, parents should be advised that a specific cause of death is not always found.

The three types of investigation most likely to give useful information are:

Post mortem

- there are two types of post-mortem examination available; full hospital exam or MRI scan (Please refer to the bereavement pack for more detailed information)
- Parents should always be given post-mortem patient information leaflets
- Parents should be given the opportunity to discuss their options
- Written consent must only be obtained by a trained individual (Doctor or Bereavement Midwife).

Placental histology

- Placental histology should be performed with verbal consent and is recommended even if post-mortem examination is declined

Fetal Chromosomal Analysis

- These tests are necessary to determine if the baby had an underlying genetic disorder
- If parents wish for genetic testing to be performed, it is necessary to complete a 'Diagnostic Genetics Service' request form and the test required is 'Karyotyping'
- If parents decline genetic testing, they should only consent to a limited post mortem and exclude genetic testing on the consent form

Parents' wishes regarding clinical investigations after a stillbirth should be clearly documented within the narrative in the care pathway.

5.14 Stillbirth/Neonatal Death Certification and Notification

Certification and notification procedures in the UK differ for babies born with signs of life (ending in a neonatal death) compared to a birth where there are no signs of life present.

Births where no signs of life are observed (IUFD/Stillbirth):

If a baby is born showing no signs of life at or after 24+0 weeks gestation, there is a legal requirement to register the death as a stillbirth. A medical certificate of stillbirth should be issued, by a doctor or midwife who has either delivered the baby or thoroughly examined the baby afterwards. The direct cause, antecedent causes and other significant conditions that are recorded on the stillbirth certificate should be recorded in the mother's notes.

A stillbirth certificate should be completed for every stillbirth and given to the parents. See **Appendix 8**

Birth at the threshold of viability (when an IUFD has NOT been confirmed):
If signs of life are observed but the baby subsequently dies, the doctor who witnessed signs of life before the death occurred must complete a Medical Cause of Death Certificate and where appropriate Part 1 of the Cremation 4 form (available in the neonatal death bereavement pack).

For all live births ending in neonatal death, a member of the care team must complete a birth notification and the family must register the birth and death. In England the death must be reported to the local Child Death Overview Panel (CDOP)(14). There is no statutory obligation to report all deaths to the Coroner, unless there is any concern that the death was unnatural.

In the case of a live birth which ends in neonatal death, disregard the (blue) stillbirth/IUFD task/documentation checklist (Appendix 8) and refer to the (orange) neonatal death task/documentation checklist (Appendix 9).

5.15 Discharge of the Mother after Stillbirth/Neonatal Death

- The woman should be reviewed and deemed clinically well by a senior obstetrician prior to discharge
- The Trust Information for Parents Following Bereavement, Leaflet 3, should be offered: “When Your Baby Dies - Going home from hospital, ongoing support and preparing for the future” **See Appendix 1.**
- Arrangements should be in place to ensure follow up care. The woman should be offered support from her named community midwife and the bereavement midwife
- A full handover of care should be given to the community midwife and the bereavement midwife (by telephone call), including details of when the woman is expecting her next visit or telephone contact
- The woman should be given relevant contact details including the 24-hour number for the birth centre
- The woman should be given a discharge information pack with a handover of care and relevant information. For recommended contents of the discharge pack **see Appendix 7**
- Families should be made aware of stillborn baby funeral requirements and options. Staff can access information regarding funerals for stillborn babies within the maternity bereavement pack **(Appendix 9)**
- All women and their partners should be offered bereavement support from the bereavement midwife. This can be provided from diagnosis of the stillbirth through the postnatal period, with continuity of care into subsequent pregnancies
- If the baby is going to the mortuary it should be transferred together with the placenta and all relevant documentation. **Refer to the SOP for the Care, storage and transfer of a fetus or stillborn baby** Care Storage And Transfer Of A Fetus Or Stillborn Baby,
- If the baby is going home with the parents refer to the SOP for Supporting Parents who wish to take their stillborn baby home
- A full task checklist and documentation checklist should be completed by midwives providing care and filed in the patient record. For task and documentation checklists **see Appendix 8**

5.16 Follow up Consultation after Stillbirth or Early Neonatal Death

- Follow up of patients who have had a stillbirth is a key element of care. It is an opportunity to assess maternal recovery from the event, both physically and psychologically; as well as to convey information about investigations performed.
- It is an opportunity to put in place a management plan for future pregnancies if that may be considered in the future. Risk factors can be reviewed and addressed including the common risk factors for stillbirth such as maternal obesity, advanced maternal age, and smoking (2) as well as others that are apparent from the maternal history or investigations.
- Return to the Maternity Unit can be difficult and it is best done in another location. Inform parents in advance where the follow up debrief visit will occur.
- Preparation is essential for any such consultation. Patients who have been through the experience of having a stillborn baby should not have the trauma of an unprepared consultation added to that experience. It should be noted what the wishes of the parents are for follow up appointments.

  Prior to consultation ensure that:
  - All results are available including placental histology and post-mortem if applicable
  - Notes of any case review are available.

  The psychological well-being of both parents should be asked about and additional help offered if needed.

See **appendix 11** for a list of recommended topics for discussion at the follow up consultation.

5.17 Care in a Subsequent Pregnancy after Stillbirth or Neonatal Death

- A history of stillbirth should be clearly marked in the case record using the appropriate sticker on the front cover and detailed on the EPR
- Carers should ensure they read all the notes thoroughly before seeing the woman
- Women with a previous unexplained IUFD should be recommended to have obstetric antenatal care, screening for gestational diabetes, and be offered serial assessment of growth by ultrasound biometry
- Maternal request for scheduled birth should consider the gestational age of the previous IUFD, previous intrapartum history and the safety of induction of labour
- Carers of women with a previous IUFD should be aware that maternal bonding can be adversely affected and should be vigilant for postpartum depression

5.18 Clinical Governance

All Stillbirths are subject to review using the national standardised Perinatal Mortality Review Tool (PMRT). The aim of the PMRT is to support objective, robust and standardised review to provide answers for bereaved parents about why their baby died. Intrapartum IUFD will be subject to review by HSIB (Healthcare Safety Investigation Branch)

- The PMRT is completed by a multi-disciplinary team in line with the PMRT SOP
- The parents' perspectives and any questions or concerns they may have regarding their care will be incorporated and addressed as part of the review PMRT parental engagement.pdf (trent.nhs.uk)

- Any care delivery issues identified through the PMRT are escalated through the Patient Safety Panel; where the case is discussed by an executive panel and a decision made as to whether it meets criteria for escalation to a Serious Incident investigation
- The issues and actions from the investigation and the outcomes of the review will be shared with the parents at an appropriate and convenient time for the family
- Learning from PMRT cases will be disseminated to maternity staff via the Monthly Governance Newsletter

6.0 Roles and responsibilities

6.1 Midwives & Obstetricians

Midwives & obstetricians should work within the multidisciplinary team to provide the best evidence-based care for women in accordance with appropriate guidance from diagnosis to delivery.

7.0 Associated documents and references

1. Births and Deaths Registration Act 1953 section 41, 2022., 2022. .
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4. Sands, 2022 Sands.org.uk. 2022. [online] Available at: <https://www.sands.org.uk/sites/default/files/SANDS-BEREAVEMENT-CARE-REPORT-FINAL.pdf> [Accessed 23 November 2021].
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7. British Association of Perinatal Medicine. 2021. *Perinatal Management of Extreme Preterm Birth Before 27 weeks of Gestation (2019)*. [online] Available at: <https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019> [Accessed 23 November 2021].
8. Legislation.gov.uk. 2021. Still-Birth (Definition) Act 1992. [online] Available at: <https://www.legislation.gov.uk/ukpga/1992/29/contents> [Accessed 23 November 2021].
9. Rcog.org.uk. 2021. [online] Available at: <https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf> [Accessed 23 November 2021]. Report of a Working Party. Termination of pregnancy for fetal abnormality. RCOG 2010.

8.0 Training and resources

Training will be delivered as outlined in the Maternity Training Needs Analysis. This is updated on an annual basis.

9.0 Monitoring and audit

Any adverse incidents relating to the Management of Stillbirth, Medical Termination of Pregnancy (MTOP) or Neonatal Death from 24+0 weeks gestation will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline 'Clinical guideline for the Management of Stillbirth, Medical Termination of Pregnancy (MTOP) or Neonatal Death from 24+0 weeks gestation' will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

9.0 Equality and Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1

Trust information leaflets for parents following bereavement; Leaflets 1, 2 and 3.

BHNFTPL0233 When Baby Dies ONE Oct 19 DL .pdf

BHNFTPL0234 When Baby Dies TWO Oct 19 DL .pdf

BHNFTPL0235 When Baby Dies THREE Oct 19 DL .pdf

Appendix 2

Table of recommended tests and investigations for the mother at the point of diagnosis of an **IUFD**:

TEST	REASON FOR TEST
MSU	To identify ascending maternal bacterial infection
HVS	
FBC	To assess maternal wellbeing and ensure prompt management of underlying conditions.
U&E	
LFT	
Serum Uric acid	
CRP	
Coagulation Screen	To identify Disseminated intravascular coagulation (DIC)
Thyroid Screen (TSH)	Thyroid dysfunction and diabetes are thought to be associated with stillbirth. This test should be performed to identify if the mother has underlying condition.
HbA1c	
Anti-Nuclear Antibody (ANA)	To detect undiagnosed autoimmune disease as a possible cause of IUD
Acquired Thrombophilia Screen (Anti Phospolipid Syndrome)	Antiphospholipid syndrome testing is recommended following stillbirth; especially when accompanied by fetal growth restriction, severe preeclampsia, or other evidence of placental insufficiency
TORCH Screen	To identify occult maternal-fetal infection; associated with stillbirth. (Toxoplasmosis, Other (syphilis, varicella-zoster, parvovirus B19), Rubella, Cytomegalovirus (CMV), and Herpes infections)
Kleihauer	To assess for lethal fetomaternal hemorrhage (to be obtained for all women regardless of blood group).
Group and Save	To identify maternal blood group and test for antibodies

Table of recommended tests and investigations to be carried out at the point of diagnosis of a **MTOP**:

TEST	REASON FOR TEST
FBC	To assess maternal wellbeing and ensure prompt management of underlying conditions.
Coagulation Screen	To identify Disseminated intravascular coagulation (DIC)
Group and Save	To identify maternal blood group and test for antibodies

Appendix 3

Table of recommended tests/investigations for women having expectant management of labour:

SCREENING REQUIRED	FREQUENCY
FBC Coagulation screen	Twice weekly

If these are abnormal, fibrinogen level/ fibrinogen degradation product tests will be required following discussion with a haematologist.

Appendix 4

Drug regime for Active Management of Labour:

STAGE 1 - PRE-INDUCTION (IUFD & MTOP) (FOR SCARRED/UNSCARRED UTERUS)			
GESTATION	**DRUG**	**ROUTE/FREQUENCY**	**COMMENTS**
>24 weeks	Mifepristone 200 mg	PO Single dose	This drug should only be administered within the maternity unit and the woman should be observed when taking the medication

STAGE 2 - INDUCTION OF LABOUR (IUFD & MTOP)				
UNSCARRED UTERUS				
	GESTATION	**DRUG**	**ROUTE/FREQUENCY**	**COMMENTS**
Unscarred uterus	24+0 to 26+6 weeks	Misoprostol 100 mcg	PV 6 hourly, (max 4 doses in 24 hours)	If not effective, discuss with Consultant - consider repeat misoprostol after 12 hour rest period
	>27+0 weeks	Misoprostol 25-50 mcg	PV 4 hourly (max 6 doses in 24 hours)	If not effective, discuss with Consultant - consider repeat misoprostol after 12 hour rest period

SCARRED UTERUS (HISTORY OF CAESAREAN SECTION)				
	GESTATION	**DRUG**	**ROUTE/FREQUENCY**	**COMMENTS**
Scarred uterus (previous LSCS)	>24+0 weeks	Misoprostol 25-50 mcg	PV 4 hourly (maximum 6 doses)	If not effective, discuss with Consultant - consider repeat misoprostol after 12 hour rest period
		OR		
		Mifepristone 600mg	Day 1 PO (stat dose)	
		Mifepristone 600mg	Day 2 PO (stat dose)	
		Cervical Ripening Balloon **OR** Misoprostol 25-50mcg	Cervical Ripening Balloon **OR** PV 6 hourly (5 doses)	

Appendix 5

Recommended tests to be performed on all stillborn babies/ placenta and sent for histology:

TEST REQUIRED	REASON
Fetal swab (Axilla)	To detect fetal infection

Placental swab (Maternal aspect)	

Appendix 6

All keepsakes are stored in the cabinet in the Rainbow Room. Each item should be explained to the family so that they understand its purpose.
The following options are available to our families for creating memories and keepsakes:

MEMORY MAKING & KEEPSAKE'S	
4Louis Memory Box (Memory box for parents)	The boxes contain items to help inspire bereaved families to capture mementos of their baby.
Jaxon's Gift Memory Box (Memory box for siblings of the stillborn)	These boxes should be offered to children who have lost a baby sibling to try and help them make sense of the loss.
Remember My Baby	'Remember My Baby' is a registered charity which offers a free baby remembrance photography service to parents experiencing the loss of their baby before, during or shortly after birth.
Hand/foot prints	The hand/footprint kits are provided by SANDS They are included in the 4Louis memory boxes or available separately from the bereavement cupboard on the Birthing Centre.
Aching Arms bear	Aching Arms bears are intended to provide a physical comforter for mothers and to signpost parents to support agencies to ensure they have high quality bereavement care, support and counselling
Henrys Hope 3D Hand & Foot castings	A local baby loss charity, Henry's Hope provide this service as part of a memory making session, they will visit the Rainbow Room and create the casts together with the family. The casts are presented either in a box frame or gift box with personalisation of baby's name, date of birth and weight etc. Providing a most special keepsake that will last forever.
Little Angel Ashes soft toy	Parents who choose to have their baby cremated, may choose to purchase a small container from the Bereavement Office at the crematorium in which to keep their baby's ashes. 'Little Angel' soft toys are available, with a zip compartment where the container of ashes may be discreetly stored. These soft toys make the perfect comforter for parents to hold their baby close.
Hand in their Heart Keyring	This is a beautiful keepsake keyring, with a cut-out heart, designed as gift for bereaved parents. The tiny heart can be placed in the baby's hand or blanket when saying goodbye and the keyring is a gift to the parents, as a beautiful tangible reminder of the connection shared with

	their baby.
Lexi Doll	Lexi dolls may be given to children who had all the expectation of a new baby coming into the family. Giving children something special to hold, cuddle and play with remembering their baby who passed away.
Treasured Blessings	The Treasured Blessing Box includes special treasures and items that can be used to create a special and comforting moment between a family and their baby. The unique words and treasures are made especially for parents who have lost a baby. The special moment is similar to a blessing, which is unique for each family, their baby and their beliefs and ideas.

Appendix 7

Table below suggests recommended literature to be provided to bereaved women at point of discharge:

DISCHARGE PACK CONTENTS	
Mothers Postnatal Notes & Handover of care	Discharge packs are pre-prepared and ready for completion for each individual patient
Leaflets for local and national bereavement support groups	
Release form	
Information about bereavement counselling services	
Contact details for Bereavement Midwife	
Information for Parents Following Bereavement; Leaflet 3	
Stillbirth certificate	
Instruction on registering stillbirth	
PMRT Investigation letter	

Appendix 8

Task and Documentation checklists for IUD or MTOP (>24 weeks)

IUFD BEREAVEMENT CHECKLISTS AUG 2022.pdf

Appendix 9

Neonatal Death Task and documentation checklist

NND BEREAVEMENT CHECKLISTS AUG 2022.pdf

Appendix 10

Stillborn baby funerals and associated documentation

Babies stillborn on or after the age of viability (24+0/40) must be legally registered and must have a funeral.

- **Parents should be offered the option to arrange the funeral with the hospital nominated funeral director, or with any other funeral director of their choice**
- **Parents have the choice of cremation or burial**
- **All basic costs will be paid by the Children's Funeral Fund for England**
  Support for child funeral costs (Children's Funeral Fund for England) - GOV.UK (www.gov.uk)

CREMATION

- Service provided at Barnsley Crematorium (15-20 minutes)
  - Minister/celebrant provided to conduct service
  - Parents can choose elements to be included in the service; readings, poems and/or music etc
- Funeral directors will discuss with family any specific wishes/requirements
- Baby will be transported in a funeral car to the crematorium in a white wooden coffin with a name plaque.
- Parents must collect the ashes from the crematorium within 4 weeks. If not collected they will automatically be scattered in the Baby Glade at Barnsley crematorium
- If parents wish to keep the ashes they may purchase an urn from the crematorium
- A plaque may be purchased from the crematorium to go in Baby Glade area at the crematorium (10 years)
- Parents can have their baby detailed in the Remembrance Book at the crematorium – the book is open at the page, for that that day, each year

BURIAL

- Parents can choose an adult/family burial plot at any cemetery or a baby burial plot at the following cemeteries:
  - Barnsley
  - Hoyland
  - Thurnscoe
  - Carlton
- Included in the basic costs covered by the children's funeral fund:
  - A car (not a hearse) to transport the baby to the cemetery
  - A casket/coffin
  - A basic 'graveside service' (not in church)
- Funeral directors will discuss with family any specific wishes/requirements.
- After approximately 3 months an initial stone is placed at the grave with the plot number and the baby's initials
- Memorial stones may be added to the grave at an additional cost to the parents (usually after 6 months)
- Parents can have their baby detailed in the Remembrance Book at the crematorium – the book is open at the page, for that that day, each year

Appendix 10 Continued

FUNERAL DOCUMENTATION		
TYPE OF FUNERAL:	**DOCUMENT:**	**INSTRUCTION:**
CREMATION	Certificate of Stillbirth (Cremation 9)	See bereavement pack checklist for instructions on completion and distribution of these documents.
	Preliminary application for cremation (Blue form)	
	Application for the cremation of stillborn baby (Cremation 3)	
BURIAL	BMBC Application for the Purchase of Exclusive Rights of Burial (Form 2)	
	BMBC Bereavement Services (Form 3)	

Appendix 11

At the follow-up consultation possible areas for discussion include the following. However, this needs to be done sensitively to the woman's individual needs:

FOLLOW UP APPOINTMENT:
Results of tests/investigations for stillbirth
Likely cause of stillbirth
Pre-pregnancy plan for next pregnancy
Smoking/alcohol status
Folic acid advice, consider low dose aspirin
BMI optimisation
Any psychological issues/ support required
Medications
Optimisation of other medical conditions
Pregnancy plan for next pregnancy
Who to contact when pregnant
Book under Consultant Obstetrician
Screen for gestational diabetes (if unexplained)
Ultrasound scan schedule
Place/type/timing of delivery for subsequent pregnancy
Consider extra precautions for post-natal depression
Feedback of the findings from PMRT/case review/serious Incident investigations

It is recommended that the meeting is documented in a letter to the parents, and copied to their GP, including and agreed outline plan for future pregnancy.

Appendix 12
Equality Impact Assessment – required for policy only
Please refer to Equality Impact Assessment Toolkit – found in Corporate Templates on PC desktop.
For clinical policies use Rapid Equality Impact Assessment Form
For all other policies use Equality Impact Assessment Blank Template

Appendix 13
Glossary of terms
List all terms/acronyms used within the document and provide a summary of what they mean.

Appendix 14 (must always be the last appendix)
Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Reviewed by Maternity Guideline Group	
Reviewed at Women's Business and Governance meeting	
Approved by CBU 3 Overarching Governance Meeting	
Approved at Trust Clinical Guidelines Group	
Approved at Medicines Management Committee (if document relates to medicines)	N/A

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Guideline
Document title	**Clinical guideline for the Management of Stillbirth, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 24+0 weeks gestation**
Document author (Job title and team)	Bereavement Midwife
New or reviewed document	
List staff groups/departments consulted with during document development	
Approval recommended by (meeting and dates):	**WB&G 21/10/22** **CBU3 B&G 02/11/2022**
Date of next review (maximum 3 years)	02/11/2025
Key words for search criteria on intranet (max 10 words)	
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the <u>FINAL</u> version of this document	**Name: Molly Claydon** **Designation: Governance Support Co-ordinator**

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): CBU3 Business and Governance
Date approved: 02/11/2022
Date Clinical Governance Administrator informed of approval: 14/11/2022
Date uploaded to Trust Approved Documents page: 17/11/2022