NHS
North West Coast
Strategic Clinical Networks

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS
in Greater Manchester

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Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

North West Management of Stillbirth

Integrated Care Pathway V4

To be used in association with the North West Management of Stillbirth Guideline V4

To be used from 24+0 weeks gestation

If less than this please see
Second Trimester Pregnancy Loss Guideline and ICP

Version 4
March 2021

Woman's Name: .....

Hospital Number: .....

In honour of all the babies who are delivered stillborn and the parents and families who experience the unimaginable

Intrauterine fetal death ≥ 24+0 weeks gestation

Integrated Care Pathway (ICP)

Woman	Baby*	Baby
Last name:	Last name:	Last name:
First name:	First name: (if applicable)	First name: (if applicable)
Hospital number:	Date of delivery:	Date of delivery:
DOB:	Gender:	Gender:
Maternal BMI:	Weight:	Weight:
Ethnicity:	Diagnosis:	Diagnosis:
Address:	Gestation:	

Woman's contact details:	Partner's name and contact details:
Consultant:	Named/allocated midwife:
G.P: G.P address:	Additional information:

Interpreter required: Yes/No	Language:
Health visitor:	Religion:

	* If one baby in a multiple pregnancy has died ask parents if they wish to use the Butterfly logo to identify this (see **NW Management of Stillbirth Guideline V4 page 7, Appendix 2).**	Accepted ☐ Declined ☐ N/A ☐

In such cases where a fetus has died <24 weeks but expelled from its mother after 24 weeks (e.g. fetal reduction, fetus papyraceous, multiple pregnancy) and its gestation is either known or provable from the stage of development or ultrasound, then the fetus does not need to be registered as a stillbirth.

The purpose of this ICP is to encourage care to the highest standards however women and families are individuals with their own needs and requirements, and variances from this pathway may occur in order to provide the best care to these women and their families.

Communication

- With parents
- Answer questions openly and honestly
- If you do not know the answer, say so and find someone who can answer the question
- With colleagues

Principles

- Ensure privacy
- Involve both parents where appropriate
- Use empathetic but unambiguous language
- Respect religious/cultural beliefs
- Provide written information
- Allow time for decision making
- Use active listening
- Repeat information
- Promote continuity of care and carer
- Involve experienced staff
- Inform relevant care providers (e.g. GP)
- Coordinate referrals
- Complete referrals
- Complete documentation

Management

Accountability

Signature	Print	Designation/Grade

Diagnosis and Immediate Care

Confirmed by ultrasound: Yes ☐ No ☐

1st practitioner's name:	Signature:	Date and time:
2nd practitioner's name:	Signature:	Date and time:

Offer the mother patient information leaflet eg RCOG "When your baby dies before birth"?	**Has the mother been informed of possible passive movements?**	**Offer to contact partner, relative or friend to offer support**
Given: ☐ Declined: ☐ Not applicable ☐	Yes ☐ No ☐ Not applicable ☐	Offered and accepted ☐ Offered and declined ☐ Partner already present ☐

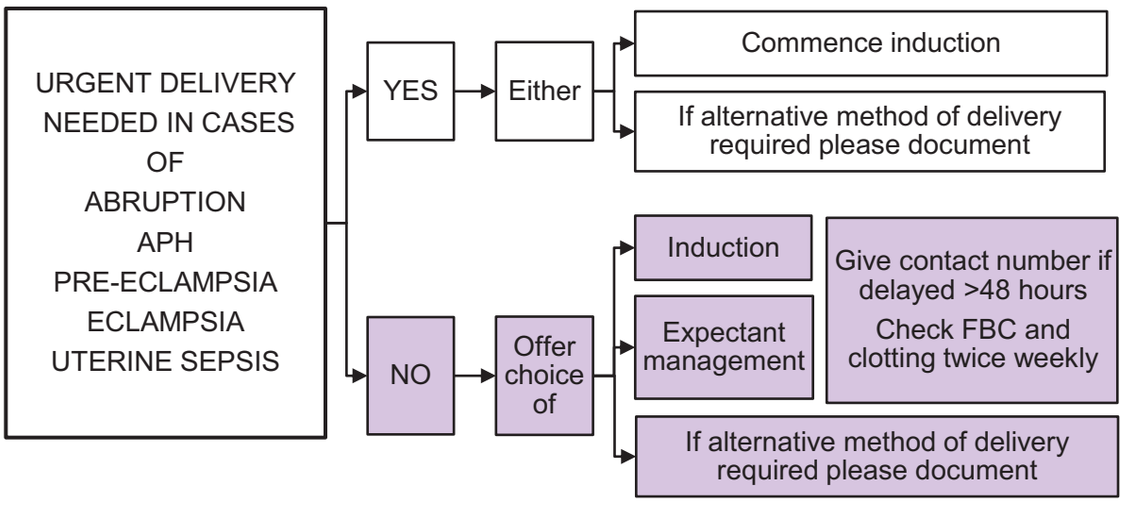
Immediate Care

Investigations at Diagnosis	**Yes**	**No**	**Results**
FBC			
PT & APTT			
U+E's			
LFT's			
Kleihauer in **ALL** women even if RhD positive			
If Rh negative give appropriate dose of Anti-D (may need further dose of anti-D after delivery)			
Group and save			

Observations		**Observations**	
Blood pressure		Respiratory rate	
Temperature		Conscious level	
Pulse		Uterine activity	
O^2 saturation		Urinalysis	

Additional Information	
Parity:	Gestation:
Obstetric issues:	Past obstetric history:
Special circumstances:	
Working diagnosis at presentation:	Date and time:

Timing of Delivery



Agreed management plan:

- If maternal cervix is favourable consider induction by amniotomy followed by oxytocin.
- If maternal cervix is unfavourable use induction regimes indicated below – use Trust medication prescription method.

Stillbirth (for termination of pregnancy see next table)

	Unscarred uterus 24+0 to 27+6 weeks gestation	Unscarred uterus 28+0 to 42 weeks gestation	Scarred uterus 24+0 to 42+0 weeks IUFD or TOP
Pre-Induction	Mifepristone 200 milligrams once only	Mifepristone 200 milligrams once only	Mifepristone 600 milligrams day 1*
	Normal interval between mifepristone and misoprostol is 0-48 hours	Normal interval between mifepristone and misoprostol is 0-48 hours	Mifepristone 600 milligrams day 2*
Induction	24+0 to 26+6 misoprostol 200 micrograms 6 hourly PV/SL/PO 5 doses 27+0 to 27+6 misoprostol 100 micrograms 6 hourly PV/SL/PO 5 doses	Misoprostol 50 micrograms 6 hourly PV/SL/PO for 5 doses	**Cervical Ripening Balloon** (advised) or Misoprostol 50 micrograms 6 hourly PV/SL/PO for 5 doses
Vaginal route for misoprostol has lower incidence of side effects such as vomiting *Women with a scarred uterus should be advised to remain in hospital during this time.			

Termination of pregnancy – unscarred uterus (for scarred uterus see previous table)

	Unscarred uterus 24+0 to 27+6 weeks gestation	Unscarred uterus 28+0to 42 weeks gestation
Pre induction	Mifepristone 200 milligrams once only PV/SL/PO	Mifepristone 200 milligrams once only
Induction	Misoprostol 200 micrograms PO/SL/PV 4 hourly, 5 doses	Misoprostol 100 micrograms PO/SL/PV 6 hourly, 5 doses

- Mifepristone contraindicated if: Uncontrolled or severe asthma, chronic adrenal failure, acute porphyria

- Misoprostol caution with conditions that are exacerbated by hypotension (cerebrovascular or cardiovascular disease) and inflammatory bowel disease

- If undelivered after a course of 5 doses, then a 2nd course can be given after a 12 hour interval. Discuss with Consultant about further management prior to a 2nd course.

Care around Diagnosis

Location of care	Yes	No	N/A	Comments	Date	Signature
Book induction admission Arrange admission to avoid arrival with other parents having induction of labour						
Emergency telephone numbers provided						
Discuss possibility of feeling passive movements if the mother had been feeling fetal movements before diagnosis						
Inform: Consultant on call Woman's own consultant				Who contacted		
Cancel antenatal, ultrasound and/or any additional appointments at other units/ children centres						
Inform other units if applicable e.g. fetal medicine unit Other teams (diabetes / cardiology / teenage pregnancy / safeguarding)				Who contacted		
Provide the parents with a compassionate car parking pass if required - detach back page of booklet (also has details of support groups for parents). If electronic / barrier parking liaise with security / car parking office to waive parking charges / lift barrier on exit						
Orientate mother to her surroundings (e.g. the bereavement/delivery suite) and explain call bell system						
Inform & provide parents with details of the bereavement midwife/family support office or equivalent lead						
If appropriate discuss delivery, postnatal investigation and management						
Offer emotional support and be sensitive. Parents will be distressed and frightened. Answer questions honestly. If you do not know the answer, say so, and find someone to assist you						
Complete an incident form						

Name	**Gestation**	**Gravida**	**Para**
Labour induced/spontaneous (please circle)	**Time of onset of labour**	**Time of spontaneous membrane rupture/ARM**	
Birth partner	**Birth preferences**		
Significant medical or obstetric history			**Blood group**

Hours	0	1	2	3	4	5	6	7	8	9	10	11	12
Time													
Liquor = Clear/Mec/BS/Nil													
Contractions 5													
per 10 minutes 4													
Weak (W) 3													
Mod (M) 2													
Strong (S) 1													

5ths Palpable												
Cervix (cm) 10												
plot ● 9												
8												
Descent of head/pp 7												
plot X 6												
-2 5												
-1 4												
0 3												
+1 2												
+2 1												
Fetal position	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Syntocinon (Y/N)													
mls per hour													

Maternal	Hours	0		1		2		3		4		5		6		7		8		9		10		11		12	
Observations	Time																										
Pulse rate (x)																											
180																											
170																											
160																											
150																											
140																											
BP 4 hourly	130																										
unless clinically	120																										
indicated more	110																										
frequently	100																										
90																											
80																											
70																											
60																											
50																											
40																											

Respiratory rate																											
Oxygen saturations																											
Maternal temperature ^{0}C																											
TOTAL MEOWS 4 hourly																											
Drugs given/oral/IV fluids																											
Urine output																											
Urine dipstick																											
Pressure areas checked																											

Signature (initial)																											

Remember to commence a fluid balance chart when appropriate and complete MEOWS chart to assess score and appropriate management

Time of birth	**Mode of birth**	**Time of cord clamping**	**Time of placenta**
Estimated blood loss	**Birthweight**	**Centile**	**Signature**

Care in Labour

This should be the same as normal care in labour as per Trust policy including use of partogram and observations. Please use bereavement specific partogram on previous page.

Ideally one to one care should be facilitated at least for the first 24 hours, though this may not always be possible during times of high activity in the maternity unit.

Labour and delivery summary		
Mode of delivery:	Perineum:	Estimated blood loss:
Placental weight g	Birthweight g	Centile

Umbilical Cord				
Fetal chromosome analysis	I consent that a sample of umbilical cord is taken for extracting DNA in order for chromosomal analysis to be performed. I understand that the sample may be stored for future diagnostic tests. Parental signature:_____ Date: _____	Sample needed 3cm section of umbilical cord placed in saline	Sample destination: Cytogenetics If baby does not have malformations for PCR only. If malformations noted then full microarray.	Offered Yes ☐ No ☐ N/A ☐ Accepted Yes ☐ No ☐ If cause for stillbirth is known then investigations may be omitted.
Number of vessels: 2 ☐ or 3 ☐ Knots in cord: Yes ☐ No ☐		Cord insertion position: (e.g. central, velamentous etc.) _____ _____		
Looped round neck? Yes ☐ No ☐ If yes number of times _____ Tight around neck? Yes ☐ No ☐ Loose? Yes ☐ No ☐		Other comments:		

Placenta		
Do not place in formalin (or other preservative as per local policy) until cord sample for chromosomal analysis (if indicated) and swabs for microbiology obtained (if required)		
Placental swabs Obtain as soon as possible	Swabs from maternal surface of placenta only	**Microbiology** Offered: Yes ☐ No ☐ N/A ☐ Accepted: Yes ☐ No ☐ N/A ☐
Manual evacuation of placental tissue Yes ☐ No ☐ If yes, was it morbidly adherent? Yes ☐ No ☐ Request form for placental pathology (see Appendix 4 in NW Management of Stillbirth Guideline V4) **Placental Pathology** Offered: Yes ☐ No ☐ If Yes; Accepted ☐ (i.e. gave verbal consent) or Declined ☐		

Care of the Stillborn Baby

	Yes	No	N/A	Comments	Date	Signature
Identify baby. Attach 2 name bands						
Weigh and measure baby						
Does the mother wish to see her baby immediately	1st offer			Should ask parents twice if not accepted 1st time		
	2nd offer					
Discuss the care of the baby with mother/parents						
Swab from baby's axilla						
Photographs: Discuss and offer memento photographs to be taken. Offer the parents the opportunity to take their own photographs. If photographs taken by Medical Illustration - verbal or written consent will need to be obtained as per Trust policy	1st offer			Should ask parents twice if not accepted 1st time		
	2nd offer					
Verbal consent for initial examination				If consented to see sheet on page 10		
Discuss personal items: • Hand and foot prints (if feasible) • Lock of hair • Name band • Cord clamp	1st offer			Should ask parents twice if not accepted 1st time		
	2nd offer					
Naming and blessing or other				Write name on pages 2 and 25 of this ICP and refer to baby with chosen name		

	Yes	No	N/A	Comments	Date	Signature
Provide the parents with the opportunity to choose clothes and blankets for the baby and to offer to start a memory box with them						
Dress baby, and carefully and respectfully lay the baby in as natural position as possible in a Moses basket/cold cot Ask parents if they would like to dress the baby themselves Use appropriately sized clothes				Some parents may wish to wash their baby. If for religious or personal reasons, parents do not wish their baby to be washed, use plain white sheets.		
Offer opportunity to hold their baby, spend time with their baby and offer the use of the cooling cot (if available) to maintain baby's skin condition. With parents' consent offer other family members to hold baby with their permission						
Offer parents opportunity to make an entry into the Remembrance Book						

Clinical Examination of Stillborn Baby

Verbal consent obtained and documented (page 8) for external examination of baby

MEASUREMENTS
Weight _____g Length _____cm
Head circumference _____cm

MACERATION
☐ Fresh: no skin peeling
☐ Slight: focal minimal skin slippage
☐ Mild: some skin sloughing, moderate skin slippage
☐ Moderate: much skin sloughing but no secondary compressive changes or decomposition
☐ Marked: advanced maceration

HANDS
☐ Normal appearance
☐ Abnormal appearance
If abnormal describe _____
_____

FINGERS
Number present _____
If not 4+4 please describe _____
_____
☐ Unusual position of fingers
☐ Looks like a finger
If abnormal describe _____
_____
☐ Abnormal webbing or syndactyly
If abnormal describe _____
_____

NAILS
☐ All present
If not, describe _____
_____

THUMBS
Number present _____
If not 1+1 please describe _____
_____

FEET
☐ Normal appearance
☐ Abnormal appearance
If abnormal describe _____
_____

TOES
Number present _____
If not 5+5, describe _____
_____
☐ Abnormal spacing
If abnormal describe _____
_____

GENITALIA
☐ Anus ☐ Normal
☐ Imperforate ☐ Other
If other please describe
_____

SEX
☐ Male ☐ Female
☐ Ambiguous

MALE
☐ Penis ☐ Normal
☐ Hypospadias ☐ Very small
☐ Chordee
If hypospadias describe level of opening
_____
☐ Scrotum ☐ Normal
☐ Abnormal
☐ If abnormal describe _____
_____
☐ Testes ☐ Descended
☐ Undescended ☐ Other
If other describe _____

FEMALE
☐ Urethral opening
☐ Present ☐ Absent/ unidentifiable
Vaginal introitus
☐ Present ☐ Absent/ unidentifiable
Clitoris
☐ Present ☐ Absent/ Unidentifiable
☐ Other – please describe_____
_____
☐ Ambiguous sex - please describe

EARS

☐ Normal ☐ Low set
☐ Pre-auricular tags ☐ Pre-auricular pits
☐ Posteriorly rotated ☐ Other

If other, describe _____

_____

NECK

☐ Normal ☐ Short
☐ Excess ☐ Cystic mass /redundant skin (hygroma)

If other, describe_____

CHEST

☐ Normal ☐ Long/narrow
☐ Short & broad ☐ Other

If other, describe _____

_____

ABDOMEN

☐ Normal ☐ Flattened
☐ Distended ☐ Hernia
☐ Omphalocele ☐ Gastroschisis

BACK

☐ Normal ☐ Spina bifida

If spina bifida, level of defect:

☐ Scoliosis ☐ Kyphosis
☐ Other

If other, describe_____

_____

LIMBS

Length

☐ Normal ☐ Long
☐ Short - which segments seem short_____

Form

☐ Normal ☐ Asymmetric
☐ Missing Parts

If abnormal describe _____

_____

Position

☐ Normal ☐ Clubfoot
☐ Other

If abnormal describe_____

_____

HEAD AND FACE

☐ Head relatively normal
☐ Collapsed ☐ Anencephalic
☐ Hydrocephalic ☐ Abnormal shape

If abnormal describe _____

EYES

☐ Normal ☐ Prominent
☐ Sunken ☐ Straight
☐ Upslanting ☐ Downslanting
☐ Far apart ☐ Close together
☐ Eyelids fused ☐ Other

If other describe _____

NOSE

☐ Normal ☐ Abnormally small
☐ Asymmetric ☐ Abnormally large
☐ Nostrils ☐ Apparently patent

If other describe_____

MOUTH

☐ Normal size ☐ Large ☐ Small
☐ Upper lip ☐ Intact ☐ Cleft*

If cleft, give location: _____

☐ Left ☐ Right
☐ Bilateral ☐ Midline

Mandible

☐ Normal size ☐ Large
☐ Small ☐ Other

Any other abnormality_____

_____

_____

Examination performed by

Name: _____

Designation: _____

Signature: _____

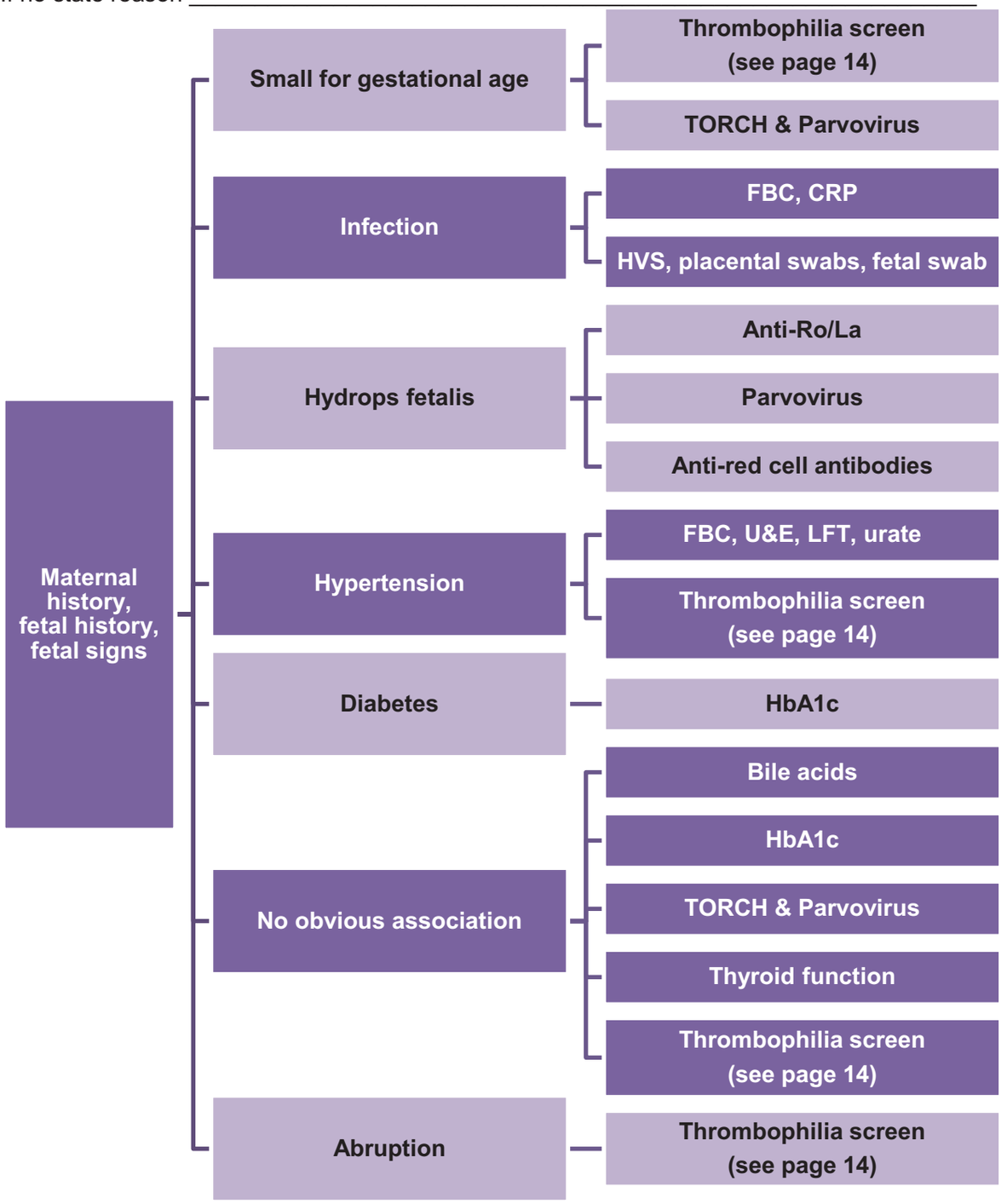
Date: _____

Investigations After Delivery - Flowchart

Relevant investigations should be confirmed with the woman's named consultant.

Further investigations needed? Yes ☐ No ☐

If no state reason _____



Investigations After Delivery – In Detail

OFFER TO ALL*	*Unless cause known and lead clinician customises further investigations					
	Other information	**What**	**Destination**	**Date**	**Yes**	**No**
Kleihauer	For all women, even if Rhesus positive					
Post mortem	Prior to consent parents should be given written patient information about a post mortem. **Leaflet offered** ☐ **Yes** ☐ **No** ☐ Accepted ☐ Declined See NW Stillbirth Guideline V4 for information on Sands patient information and parent support group Parents need consenting by an appropriately trained individual, limited post mortem may be performed **Consent obtained** ☐ **Yes** ☐ **No** ☐ Accepted ☐ Declined	Use consent form found in Appendix 3 of the Stillbirth Guideline. Report all infectious agents to the pathologist (for example coronavirus, hepatitis, HIV).				
Maternal serology	Toxoplasma, Rubella, CMV, Parvovirus B19	Maternal blood	Microbiology			
If clinically suspected maternal infection						
Maternal infection screen	If maternal flu-like illness, abnormal coloured liquor or prolonged ruptured membranes	Blood cultures, MSU, high vaginal swab, endocervical swab (inc for Chlamydia spp),	Microbiology			
Fetal infection screen		Swab from baby's axilla Placental swabs from maternal aspect only	Microbiology			

If birthweight < 10th centile on customised chart/ placental abruption/placental insufficiency/pre-eclampsia/no obvious cause						
	Other information	**What**	**Destination**	**Date**	**Yes**	**No**
Thrombophilia screen	At delivery episode	Lupus anticoagulant, Anticardiolipin antibodies, Anti-beta2 glyco protein1, antibodies Factor V Leiden, Prothrombin gene variants	Haematology			
	At least 6 weeks postnatal	Protein C, Protein S, Antithrombin				
	If positive on previous test repeat: At least 12 weeks postnatal	Lupus anticoagulant, Anticardiolipin antibodies	Haematology			
Other presentations						
If hydrops fetalis	Maternal anti Ro and La antibodies; red cell antibody screen; clinical genetic examination; skeletal survey; placental pathology (offer post mortem even if declined previously)		Blood transfusion			
If maternal substance use						
Urine for cocaine metabolites	Only if suspected maternal substance abuse. **Needs maternal consent**	Urine for cocaine metabolites	Chemical pathology			
If fetal intracranial haemorrhage (at post mortem)	Maternal alloimmune antiplatelet antibodies		Immunology			
If there is no obvious cause apparent clinically	Maternal thyroid function tests; HbA1c; bile acids; thrombophilia screen (see above)		Chemical pathology			
Parental chromosomes	Only needed if 1 Unbalanced fetal karyotype found 2 Fetal chromosome analysis fails and there is: a) Fetal abnormality on USS or PM b) Previous unexplained stillbirth c) Recurrent miscarriages		Cytogenetics			
Other investigations						

Perinatal Death Certification

General points

- The Medical Certificate of Stillbirth is a legal document and must be accurate. Accurate determination of the cause of stillbirth is important for understanding the causes of, and preventing, stillbirth.
- The ReCoDe classification should be used to guide the classification of stillbirth and to write the certificate.
- An MDT rapid case review within <24 hours in all cases of stillbirth with senior obstetric involvement (Consultant or senior registrar) can aid in identifying the cause. It is essential that the predisposing factors, pregnancy chronology, presentation and postnatal events are reviewed.
- See the "4Ps of perinatal death certification" as a structure for considering which items should be reviewed.

Stillbirth notification completed	**Date:**
Stillbirth certificate completed	**Date:**

Certification must be performed by a fully registered doctor or midwife who

- was present at the birth
- or who has examined the baby after birth

If doubt about status of birth – Inform the Coroner
If there is suspicion of a deliberate action – Inform Police

If death clearly occurred before 24 weeks but delivered after 24 weeks certification and registration is not necessary.

Signature:	Name:
Designation:	
Registration Number (PIN/GMC):	

Cause of stillbirth recorded on certificate:		If no obvious case state "No obvious cause, awaiting further investigation"
(A)	Main diseases or conditions in fetus	
(B)	Other diseases or conditions in fetus	
(C)	Main maternal diseases or conditions affecting fetus	
(D)	Other maternal diseases or conditions affecting fetus	
(E)	Other relevant causes	

Registration

- Parents must be informed that legally their baby's stillbirth must be registered (on rare occasions by next of kin).
- Please note: If the mother is remaining an inpatient but husband (married only) is registering the stillbirth at the Registrar's Office send him with the stillbirth certificate and instructions on what to do.
- If the parents are unmarried but want to have the father's surname entered, the couple must present together.
- If same sex couple notify Registrar prior to appointment.
- Give stillbirth certificate to parents if required (see local policy as stillbirth certificate may be required to be emailed to the registry office or Trust bereavement office)

Registered in hospital before discharge	Yes ☐ No ☐ N/A ☐
Went home prior to registration with instructions on how to register	Yes ☐ No ☐ N/A ☐

- In extenuating circumstances, such as maternal death, the responsibility for registration may be delegated to the hospital after discussion with the Registrar

Before writing certificate note the following:

- The gestation should be recorded as the gestation at which fetal death *in utero* was diagnosed (e.g. by scan) regardless of the date of delivery
- If post mortem is being held indicate this.
- Whilst parents cannot legally influence what is included on the Medical Certificate of Stillbirth it is good practice to discuss what will be included on the certificate with the parents prior to issue.
- If a medical termination of pregnancy has occurred (even if for lethal fetal anomaly), the direct cause of death is iatrogenic if the fetus had a heartbeat at the commencement of the procedure.
- The sequence of recorded events should reflect the most likely sequence to result in stillbirth on the basis of available evidence
- Whilst the ReCoDe classification provides a category of 'I' for unexplained cases, this should only be used if there are no other potential causes identified after judicious MDT case review.

ReCoDe Classification of Stillbirth

(A)	**Fetus**	1. Lethal congenital anomaly 2. Infection 2.1 Chronic – e.g. TORCH 2.2 Acute 3. Non-immune hydrops 4. Iso-immunisation 5. Feto-maternal haemorrhage 6. Twin-twin transfusion 7. Fetal growth restriction 8. Other	Usually fetal direct (A) Consider fetal indirect (B) and other contributory (E)
(B)	**Umbilical cord**	1. Prolapse 2. Constricting loop or knot 3. Velamentous insertion 4. Other	Usually fetal direct (A)
			Usually fetal indirect (B)
			May be fetal direct (A) or indirect (B)
(C)	**Placenta**	1. Abruptio 2. Praevia 3. Vasa praevia 4. Placental insufficiency/infarction 5. Other	Usually fetal direct (A)
			May be fetal direct (A) or indirect (B)
			Usually fetal direct (A)
(D)	**Amniotic fluid**	1. Chorioamnionitis 2. Oligohydramnios 3. Polyhydramnios 4. Other	May be fetal direct (A) or indirect (B)
(E)	**Uterus**	1. Rupture 2. Other	Often maternal direct (C)
(F)	**Mother**	1. Diabetes 2. Thyroid disease 3. Essential hypertension 4. Hypertensive disease in pregnancy 5. Lupus/antiphospholipid syndrome 6. Cholestasis 7. Drug abuse 8. Other	May be maternal direct (C) Consider maternal indirect (d) and other contributory (E)
(G)	**Intrapartum**	1. Asphyxia 2. Birth trauma	Usually fetal direct (A)
(H)	**Trauma**	1. External 2. Iatrogenic (e.g. MTOP in case of lethal congenital anomaly)	Usually fetal direct (A) Consider maternal direct (C) or indirect (D)
(I)	**Unclassified**	1. No relevant condition identified 2. No information available	Usually fetal direct (A)

Perinatal Death Certification – the 4 Ps

Predisposing factors

Risk factors

Any identifiable maternal risk factors?

- eg morbid obesity, smoking, hypertension
- If YES likely contributory (E) but if direct consider (C) / indirect (D)

Pregnancy Course

Evidence of FGR or placental insufficiency?

- Review customised centile chart and calculate IBC

FGR implicated by:

- IBC <10th centile
- Static ↓ growth trajectory on scans
- IBC compared to scan reveals static growth pattern
- Static SFH measurements in absence of any other data

If FGR present consider (A)

Is there abnormal liquor volume (without SROM history)?

- If YES may implicate placental insufficiency. If both present consider FGR in (A) and placental insufficiency in (B)
  If FGR not present then consider placental insufficiency in (A)

Was termination of pregnancy conducted?

- Direct cause of death consider (A)
- If medical termination of pregnancy conducted this should be recorded in (A) with consideration of reason for termination in "b" (fetal abnormality/fetal reduction or (C) (maternal health condition)

Multiple pregnancy?

- Usually (B) with direct cause (e.g. TTTS/ FGR etc in (A))

Presentation

At labour/delivery

- Abnormal bleeding? Consider abruption/praevia in (A)
- Stillbirth following bleeding vasa praevia at ARM should be considered iatrogenic (A) but vasa praevia itself would be (B) in this instance
- Cord prolapse? Consider (A)
- Chorioamnionitis? Consider (A)
- Birth trauma e.g. shoulder dystocia, consider (A) but acknowledge underlying cause (e.g. diabetes) in (B)
- Terminal CTG with no identifiable underlying cause may imply birth asphyxia in (A)

Postnatal events

Placental examination:

- Placental abnormality (eg infarction, ruptured vessel in membranes (i.e vasa praevia) or significant retroplacental clot)? Consider (A)
- Small placenta may indicate placental insufficiency. Consider in (A) if direct, or (B) if indirect
- Tight true knot in cord? If YES consider cord factors in (A)

Neonatal examination:

- Congenital abnormality confirmed by paediatric examination? If YES and direct consider (A), indirect (B) and contributory (E)
- Cord marks tight enough to leave mark? If YES consider cord factors in (A)

Maternal symptoms

- Have new medical conditions developed? E.g. hypertension ± proteinuria, raised bile acids. If YES and direct consider (C), indirect (D) and contributory (E)
- Positive Kleihauer? If YES consider (A)

Postnatal Care of Mother

	Yes	No	N/A	Comments	Date	Signature
Discuss suppression of lactation If accepted give cabergoline 1mg. If declined or contraindicated to discuss alternative methods				Cabergoline contraindicated if allergy to ergot alkaloids, history of puerperal psychosis, pulmonary/pericardial/ retroperitoneal fibrosis and cardiac valvulopathy. Caution with hypertension and pre-eclampsia		
If the woman chooses to donate colostrum or breast milk, discuss milk donation				See NW Stillbirth Guideline V4 page 16		
Check FBC and check result is reviewed during admission						
If RhD negative discuss with transfusion about dose of anti D required for further prophylaxis				Note that a further dose is usually needed even when given at time of diagnosis		
Obtain the woman's consent to attach a tear drop sticker or other bereavement logo to the cover of the notes including the date of delivery				Verbal consent acceptable		
Complete the bounty suppression form or activate local agreement						
Ensure a Consultant Obstetrician reviews the woman during admission						
Discuss postnatal recovery and expectations						
Thromboprophylaxis risk assessment						
Contraceptive options discussed						

Complete Postnatal Discharge

	Yes	No	N/A	Comments	Date	Signature
Discharge woman as per Trust policies						
Ensure the woman has any take home drugs she may require including analgesia or low molecular weight heparin						
If the woman booked at another Trust, please inform their Bereavement Midwife of the pregnancy loss.						

Postnatal Care of Mother

Follow Up – Community Midwife arrangements

	Yes	No	N/A	Comments	Date	Signature
Does the woman consent to a community midwife visit?						
If a visit is declined: Still notify the community midwife about the stillbirth event to make midwife aware and avoid inappropriate contact						
Does the woman consent to a health visitor visit?						
Inform GP by posting discharge summary to the surgery, highlighting the stillbirth outcome. If community midwife visit is declined, advise woman to see her own GP						
Inform health visitor (see example letter in guideline)						
Ensure that the parents have all the relevant contact details if there are complications following discharge. Options are: -Bereavement midwife -Community midwife -Maternity triage -Delivery suite -Consultant's secretary						
Offer advice regarding expected emotional reactions and difficulties. Provide information leaflets with support groups and contact numbers in the back of the leaflets				Document leaflets given		
Inform the parents that they are able to come back to spend time with their baby if they wish. Advise that they should phone to arrange this in advance				Advise where viewing would take place. Inform parents sensitively that natural changes may occur. This is influenced by the condition of the baby from delivery and the degree of maceration present.		

Postnatal Care of Mother

	Yes	No	N/A	Comments	Date	Signature
Explain Perinatal Mortality Review Tool (PMRT) review process to the parents Record parents' questions in the box below.						
Give PMRT leaflet to parents (local or national)						
Inform PMRT lead to ensure review is scheduled						
Leave the medical notes for all women not consenting to a post mortem for the bereavement midwife or nominated individual to complete national Perinatal notification (currently MBRRACE Perinatal Death Surveillance). Notify person responsible for completing MBRRACE form						
Inform parents of annual Service of Remembrance						
Arrange a postnatal debrief appointment				It may take between 8 and 12 weeks for all investigations results to be received. In the meantime, remind the woman to make contact with her G.P. regarding her wellbeing		

Parent questions for Perinatal Mortality Review Tool review:

Please note parents have 28 days to submit questions. If there are no immediate questions, the bereavement midwife should make contact within 28 days to ask parents again.

Transfer of Baby to the Hospital Mortuary

	Yes	No	N/A	Comments	Date	Signature
Check baby's identity labels Complete the relevant labels/ documentation for your unit, these must be placed with the baby						
Toys and personal items may be placed with the baby for transfer						
The baby can remain dressed if the parents wish, for transfer to the mortuary						
The copy of the post mortem form must travel securely with the baby if to be performed						
The maternal case notes (original or copy case notes) must be sent with the baby if the parents have requested a post mortem examination						
Prepare baby for transfer. For example, pram or Moses basket						
If parents wish, make arrangements to accompany parents who may wish to carry or carry baby for them						
All appropriate funeral (burial/cremation) documentation should be clearly identified and accompany the baby to the mortuary						
Telephone the mortuary to inform them of the transfer and log call						
If baby is going home inform mortuary lead						

Taking a Stillborn Baby Home

	Yes	No	N/A	Comments	Date	Signature
There is no legal reason why the parents may not take their stillborn baby home/directly to funeral directors				However, if the baby is to have a post mortem examination the parents must be informed that by taking their baby home it may affect the post mortem examination on their baby. Liaise with mortuary on the process to be agreed		
The baby must be taken home in an appropriate casket or Moses basket. The parents then have legal responsibility for arranging baby's funeral						
The means of transport home must be appropriate i.e. private and not public transport				How intend to transport?		
Ensure parents have relevant documents before transporting baby, as per local policy				Documents given		
Complete appropriate documentation for releasing baby from the ward and refer to local guidance						

Funeral Arrangements

	Yes	No	N/A	Comments	Date	Signature
Discuss options available for burial/cremation of their baby. Provide local leaflets / Sands booklet. If the parents would like the hospital to help them with the funeral arrangements, refer the parents to the bereavement team as per local hospital arrangements. Document what arrangements are likely to be carried out.						
Once the stillbirth has been registered the Registrar will issue a certificate for burial or cremation (stillbirth)						
If the family are choosing to have hospital burial or cremation the certificate for burial or cremation (stillbirth) should be given to the dedicated individuals as highlighted in your trust policy, i.e. mortuary or bereavement centre						
If the family are arranging their own funeral the certificate for burial or cremation (stillbirth) should be sent with the family and advise them to give to their funeral director						
If the parents choose to have a hospital cremation or a private cremation the form/notification must be sent to the mortuary with the baby				If hospital cremation ask parents what they wish to do with the ashes. If they wish to collect them advise when and where this will occur. If ashes to be retained follow local guidance		

Debrief Visit Prompt List

Date: _____

Ensure woman has appropriate support (e.g. partner, friend, translator, other special need)

Date of stillbirth: _____ Baby's name: _____

Counselling offered Yes ☐ No ☐ Already receiving ☐ Other ……

General Points Discussed

☐ Smoking ☐ Safe alcohol consumption ☐ Contraception
☐ BMI ☐ Folic acid prophylaxis ☐ Emotional needs

☐ Other medication eg aspirin:_____

Investigation Results

	Performed		Result
	Yes	No	
Post mortem			
Placental pathology			
Fetal chromosome analysis			
Fetal axillary swab			
Placental swabs			
Kleihauer			
TORCH and parvovirus B19			
Thrombophilia screen			
Other investigations as per clinical presentation			
Review Perinatal Mortality Review Tool (PMRT) report			

Final Diagnosis

Any other issues to be addressed/referrals/further investigations

Plan for future pregnancy

Who to contact when pregnant	
Consider referral to Rainbow Clinic, Fetal Medicine Unit or Preterm Birth Clinic	
Antenatal plan of care	
Timing of delivery	
Place of delivery	
Mode of delivery	

Best practice is to write a letter to the parents with a copy to the GP following this consultation. If the mother declines write to the GP only.

Notes

Notes

Support Organisations and Groups

National

ARC Antenatal Results & Choices

Support for parents whose baby is diagnosed with a fetal abnormality in pregnancy.
Helpline: 0207 713 7356 (available Tuesday and Thursday evenings 8pm to 10pm).
Email: info@arc-uk.org
Website: www.arc-uk.org/

Bliss for babies born sick or premature

Family support helpline offering guidance and support for premature and sick babies.
Email hello@bliss.org.uk (response within 3–5 working days)
Website: www.bliss.org.uk/

Child Bereavement UK

Supports families and educates professionals when a baby or child of any age dies or is dying, or when a child is facing bereavement.
Helpline: 0800 028 8840
Website www.childbereavementuk.org

Child Death Helpline

For all those affected by the death of a child.
Helpline: 0800 282 986 or 0808 800 6019
Website: http://childdeathhelpline.org.uk/

Cruse Bereavement Care

For adults and children who are grieving.
Helpline: 0808 808 1677
Website: https://www.cruse.org.uk/get-help

Daddies with Angels

Advice and support to male family members following the loss of a child/children.
Website: https://www.daddyswithangels.org/

Jewish Bereavement Counselling Service:

Supporting Jewish individuals through loss and bereavement
Helpline: 020 8951 3881
Email: enquiries@jbcs.org.uk
Website: www.jbcs.org.uk

Lullaby Trust

Bereavement support to anyone affected by the sudden and unexpected death of a baby.
Helpline: 0808 802 6868
Email: support@lullabytrust.org.uk
Website: http://www.lullabytrust.org.uk

MIND

Promoting and supporting people with mental health problems.
Infoline: 0300 123 3393
Website: http://www.mind.org.uk/

Petals Baby Loss Counselling Charity

Free counselling service to support women, men and couples through the devastation of baby loss.
Helpline: 0300 688 0068
Website: www.petalscharity.org

Samaritans

Confidential emotional support in times of despair.
Telephone: 116 123
Website: www.samaritans.org

Sands Stillbirth & Neonatal Death Charity

Support for families affected by the death of a baby before, during or shortly after birth.
Helpline: 0808 164 332
Email: helpline@sands.org.uk
Website: http://www.uk-sands.org

Saneline

Emotional support and information for people with mental health problems
Phone: 0845 7678000
Website: http://www.sane.org.uk/

Twins Trust

Bereavement and special needs support groups
Email: enquiries@twinstrust.org
Website: www.twinstrust.org/bereavement

The Miscarriage Association

Support for parents who have experienced miscarriage
Helpline: 01924 200799 (9am to 4pm)
Email:info@miscarriageassociation.org.uk
Website: www.miscarriageassociation.org.uk/

The Compassionate Friends UK

Offering support to bereaved parents and their families
Helpline: 0845 123 2304
Email: info@tcf.org.uk
Website: www.tcf.org.uk

Tommy's

Information and support for parents on coping with grief after having a stillborn baby.
Bereavement-trained midwives available Monday to Friday, 9am to 5pm
Helpline: 0800 0147 800
Website: tommys.org/stillbirth-information-and-support

Regional

Children of Jannah

Support for bereaved Muslim families in the UK, based in Manchester.
Helpline: 0161 480 5156
Email: info@childrenofjannah.com
Website: www.childrenofjannah.com

Listening Ear

Free self-referral counselling to help deal with anxiety, bereavement and depression.
Helpline: 0151 488 6648
Email: enquiries@listening-ear.co.uk
Website: http://listening-ear.co.uk/

North West Forget me not's & Rainbows

Support any member of the family who has been affected by the loss of a baby, during pregnancy, at birth or afterwards.
Facebook: nwforgetmenotsandrainbows

Once Upon A Smile

Children's bereavement support
Phone: 0161 711 0339
Website: www.onceuponasmile.org.uk

Parking Permit

Authorised by (PRINT NAME) _____ Authoriser's signature_____

Authoriser's contact phone number _____ Date of issue _____

This permit (to be displayed on the dashboard) has been issued for exceptional circumstances and entitles the user to free parking at the hospital site for 1 week.

Start date _____

End date _____

If electronic / barrier parking liaise with security / car parking office to waive parking charges / lift barrier on exit

Greater Manchester and Eastern Cheshire Strategic Clinical Networks
Greater Manchester Health and Social Care Partnership
4th Floor | 3 Piccadilly Place | Manchester | M1 3BN
http://www.gmhsc.org.uk/ http://www.gmecscn.nhs.uk/

North West Coast Strategic Clinical Networks
Vanguard House | Sci-Tech Daresbury | Keckwick Lane |Daresbury | Halton | WA4 4AB
https://www.nwcscnsenate.nhs.uk/