In honour of all the parents and families who have experienced a pregnancy loss

North West Management of Second Trimester Pregnancy Loss

Integrated Care Pathway V3

Ensuring optimal management for families who experience a second trimester pregnancy loss

To be used from 13+0 weeks to 23+6 weeks gestation in association with the NW Management of Second Trimester Pregnancy Loss Guideline

From 24+0 weeks please see NW Stillbirth Guideline and ICP

Guidelines produced by:
NHS Greater Manchester and Eastern Cheshire Strategic Clinical Networks
NHS North West Coast Strategic Clinical Networks

August 2022

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

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

Management

Signature	Print	Designation/grade

Second Trimester Pregnancy Loss 13+0-23+6 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 if known:	Gender if known:
Maternal BMI:	Weight:	Weight:
Ethnicity:	Diagnosis:	Diagnosis:
Address:	Gestation:	

Woman's contact details:	Partner's name and contact details:
Consultant:	Partner's ethnicity
Language:	Interpreter required: Yes/No
Religion:	Named / allocated midwife:
G.P: G.P address:	Additional information:

Additional information	
Gravidity:	Parity:
Past obstetric history:	
No. of previous miscarriages: 1st Trimester:	2nd Trimester:
Past medical history:	
Special circumstances:	
Working diagnosis:	Date and Time:

The purpose of this ICP is to encourage the highest standards of care, however women and families have individual needs and requirements, therefore variances from this pathway may occur.

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 relevant patient information leaflet Miscarriage Association "Late Miscarriage: Second Trimester Loss" or RCOG When your baby dies before birth" (from 16+0)

Given ☐ Declined ☐ Not applicable ☐

Has the mother been informed of possible passive movements?

Yes ☐ No ☐ Not applicable ☐

Offer to contact partner, relative or friend to offer support

Offered and accepted ☐ Offered and declined ☐ Partner already present ☐

Immediate Care

Investigations at diagnosis:	Yes	No	Results
FBC / group & save if required			
PT & APTT			
Kleihauer in all RhD negative women and if clinical suspicion or trauma to abdomen in RhD positive			
If Rh negative give appropriate dose of Anti-D if fetal genotype known to be Rh positive or if unknown			

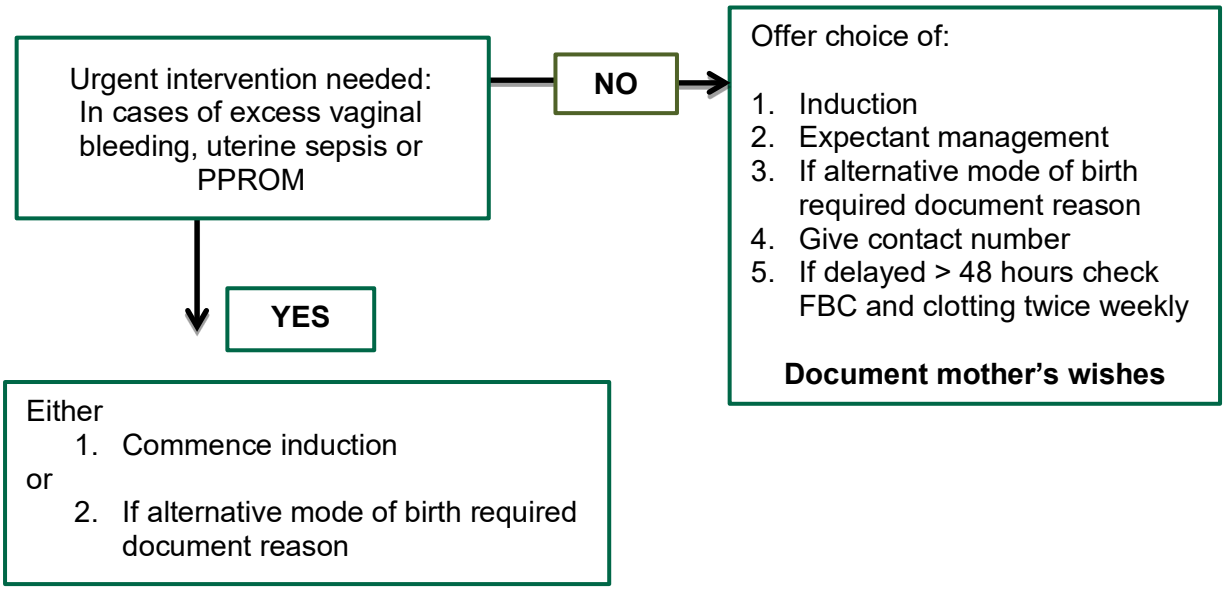
Observations:			
Blood pressure		O2 saturation	
Temperature		Conscious level	
Pulse		MEOWS	
Respiratory rate		Urinalysis	

Infection screen indicated?	Yes	No	Results
HVS and endocervical swabs			
Throat swabs			
MSSU			
CRP			
Blood cultures			
Antibiotics Indicated? Broad spectrum			

* 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 Second Trimester Pregnancy Loss Guideline V3, section 4)**

Accepted ☐ Declined ☐ Not applicable ☐

Timing of Birth



Termination of Pregnancy for Fetal or Maternal Reasons

	Yes	No	N/A	Comments	Date	Signature
Ensure the HSA1 form has been completed and signed by 2 medical practitioners						
If more than 21+6 days confirm that feticide has been performed (unless a lethal anomaly which is exempt from feticide)						
Advise the parents of the possibility that if the baby is under 22+0 weeks the baby may be born with signs of life (comfort care will be offered)						
Following all terminations HSA4 form should be completed online						

[previous section title TOPFA; updated 26/5/23]

Induction Regime

	Fetal Loss 13+0 – 23+6 weeks		Termination of pregnancy 13+0 – 23+6 weeks	
Pre-Induction	Mifepristone 200 milligrams orally once only			
Normal interval between mifepristone and misoprostol is 24 hours to 48 hours though this can be shortened if clinically needed.				
	Unscarred uterus	Scarred uterus	Unscarred uterus	Scarred uterus
Induction	Misoprostol 200 micrograms, 6 hourly, for 4 doses pv	Misoprostol 100 micrograms 6 hourly, for 4 doses pv	Misoprostol 400 micrograms, 3 hourly, for 5 doses pv	Misoprostol 200 micrograms, 3 hourly, for 5 doses pv
Vaginal route preferable due to lower incidence of side effects. (Avoid vaginal route if bleeding or signs of infection) Misoprostol can also be given sublingual (under the tongue) or buccal (in the cheek). Individual maternity units may choose to follow local protocol				
If birth not achieved after the recommended doses above, discuss with the Consultant. A second course of misoprostol can be given after a 12 hour interval.				
Syntometrine or oxytocin should be used for third stage as per the local policy. If there is a delay in delivery of the placenta by more than 30 minutes after the fetus, an additional dose of misoprostol can be given.				

* 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 membranes are intact
Use induction regimes indicated above – use Trust drugs prescription sheet.

If the membranes are ruptured
There is no evidence in the literature as to an optimal regime for induction when the cervix is dilated and/or the membranes are ruptured. If the attending doctor wishes to avoid the use of vaginal misoprostol, buccal or sublingual misoprostol or intravenous oxytocin may be considered. A recent randomised prospective trial has shown that oxytocin is as efficient as misoprostol in inducing labour in second trimester miscarriage. However, the oxytocin regime has a longer mean time to birth.

Communication Following Diagnosis

Location of care	Yes	No	N/A	Comments	Date	Signature
Book medical management/compassionate induction date, time and ward. Provide relevant emergency ward telephone numbers. Arrange admission to suitable room for bereaved parents avoiding arrival with other parents.						
Emergency telephone numbers provided:						
Discuss possibility of feeling passive movements if the mother had been feeling fetal movements before diagnosis						
Inform: • Consultant • Consultant's secretary • Bereavement midwife				Who contacted		
Cancel antenatal, ultrasound and/or any additional appointments at other units/ children centres.						
Inform other units if applicable: Eg. Fetal medicine unit Other specialities (diabetic team/cardiology/ teenage pregnancy/safeguarding team).				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 (eg the bereavement/delivery suite/gynae ward) and explain call bell system.						
Inform & provide parents with details of the bereavement midwife/family support office or equivalent lead.						
If appropriate discuss giving birth, 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 if more than 22 weeks.						

Births at 22+0-23+6 Weeks

The table below should be used to individually risk assess each baby and guide appropriate management. This table is taken from the BAPM Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation (published October 2019).

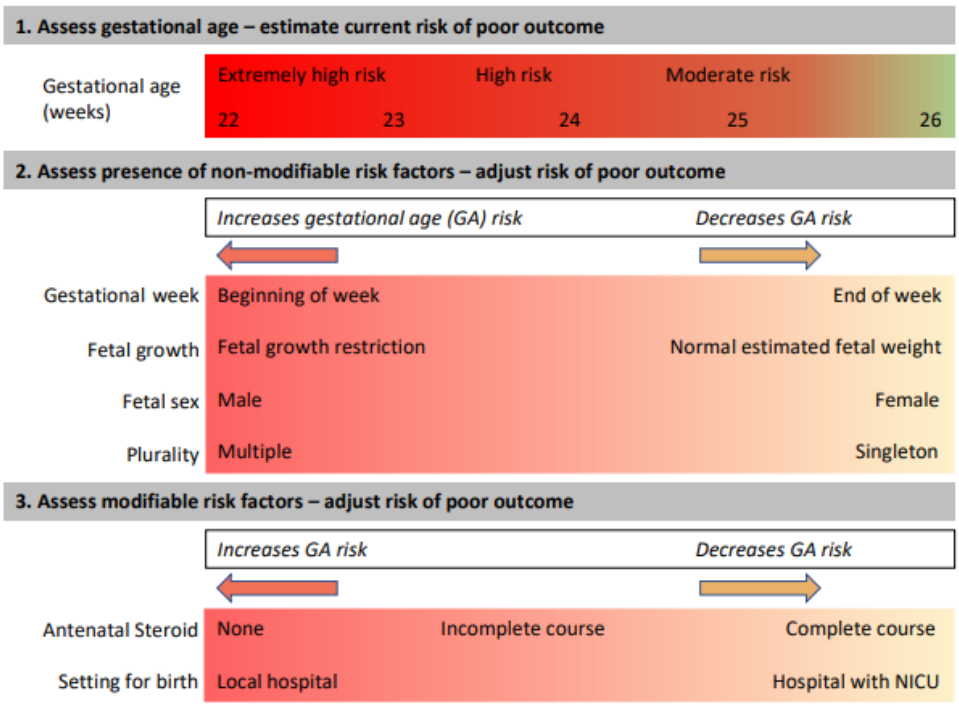


Figure 1: Proposed visual tool for refinement of risk

BOX 1

Extremely high risk: The Working Group considered that babies with a > 90% chance of either dying or surviving with severe impairment if active care is instigated would fit into this category. For example, this would include:

- babies at 22^{+0} - 22^{+6} weeks of gestation with unfavourable risk factors
- some babies at 23^{+0} - 23^{+6} weeks of gestation with unfavourable risk factors, including severe fetal growth restriction
- (rarely) babies ≥ 24^{+0} weeks of gestation with significant unfavourable risk factors, including severe fetal growth restriction

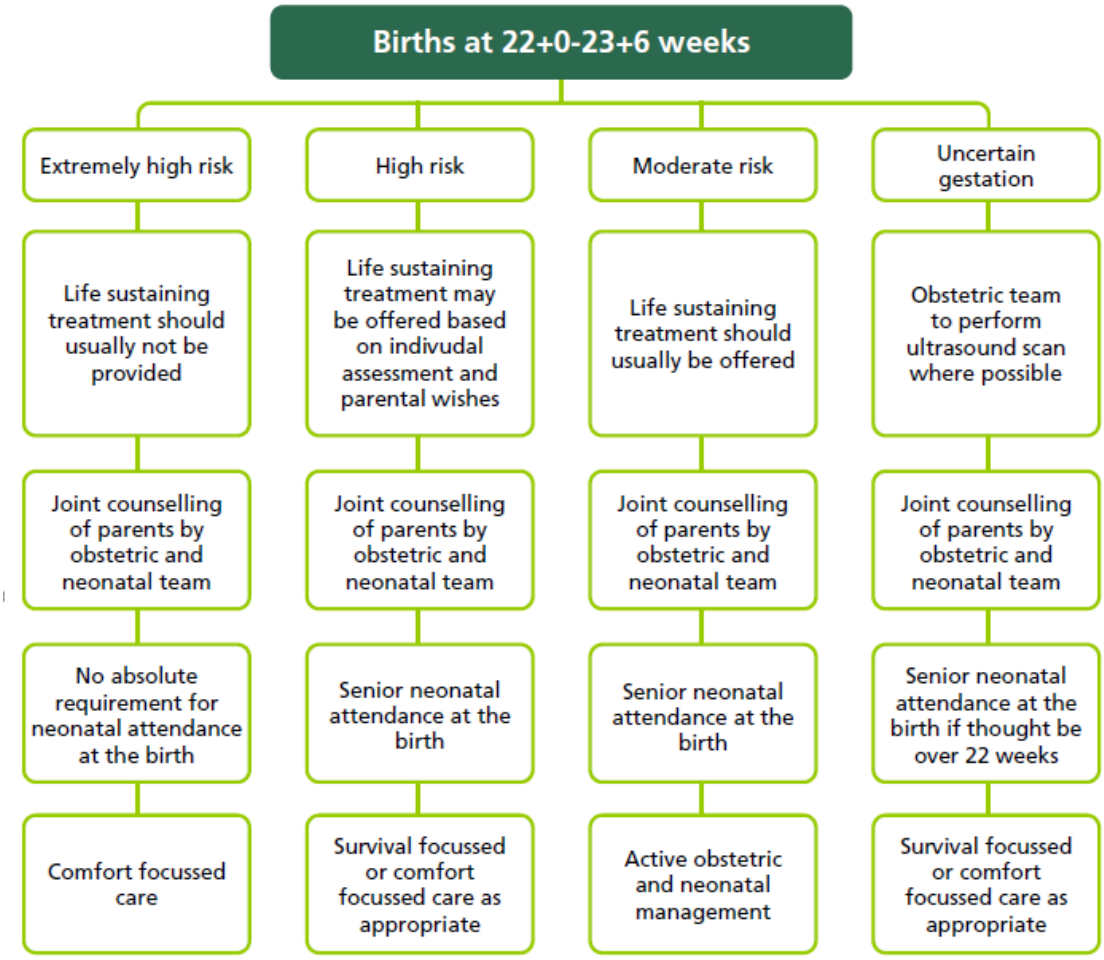
High risk: The Working Group considered that babies with a 50-90% chance of either dying or surviving with severe impairment if active care is instituted would fit into this category. For example, this would include:

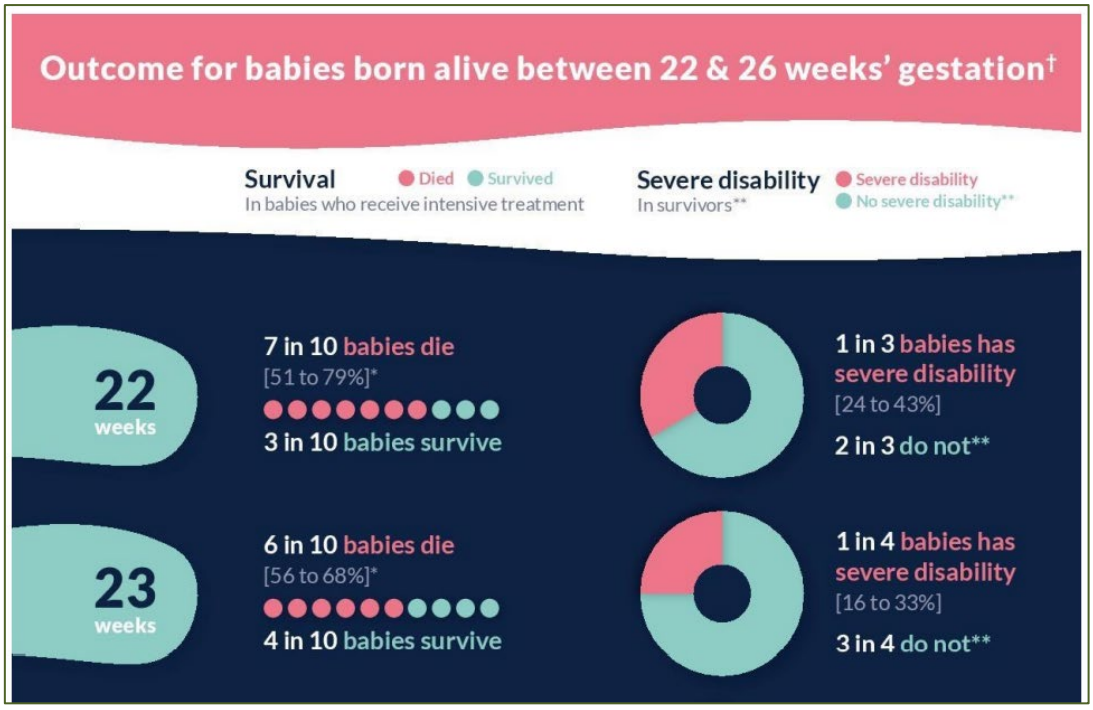
- babies at 22^{+0} - 23^{+6} weeks of gestation with favourable risk factors
- some babies ≥ 24^{+0} weeks of gestation with unfavourable risk factors and/or co-morbidities

Moderate risk: The Working Group considered that babies with a < 50% chance of either dying or surviving with severe impairment if active care is instituted would fit into this category. For example, this would include:

- most babies ≥ 24^{+0} weeks of gestation
- some babies at 23^{+0} – 23^{+6} weeks of gestation with favourable risk factors.

Box 1 represents the consensus of the [BAPM] working group in regard to risk categories for the framework (BAPM 2019)


Births at 22+0-23+6 weeks
Extremely high risk
High risk
Moderate risk
Uncertain gestation
Life sustaining treatment should usually not be provided
Life sustaining treatment may be offered based on indivudal assessment and parental wishes
Life sustaining treatment should usually be offered
Obstetric team to perform ultrasound scan where possible
Joint counselling of parents by obstetric and neonatal team
Joint counselling of parents by obstetric and neonatal team
Joint counselling of parents by obstetric and neonatal team
Joint counselling of parents by obstetric and neonatal team
No absolute requirement for neonatal attendance at the birth
Senior neonatal attendance at the birth
Senior neonatal attendance at the birth
Senior neonatal attendance at the birth if thought be over 22 weeks
Comfort focussed care
Survival focussed or comfort focussed care as appropriate
Active obstetric and neonatal management
Survival focussed or comfort focussed care as appropriate


Outcome for babies born alive between 22 & 26 weeks' gestation†
Survival
In babies who receive intensive treatment
Died
Survived
Severe disability
In survivors**
Severe disability
No severe disability**
22 weeks
7 in 10 babies die
[51 to 79%]*
3 in 10 babies survive
1 in 3 babies has severe disability
[24 to 43%]
2 in 3 do not**
23 weeks
6 in 10 babies die
[56 to 68%]*
4 in 10 babies survive
1 in 4 babies has severe disability
[16 to 33%]
3 in 4 do not**

(BAPM 2019)

Active Survival Focussed Obstetric Management

When it has been agreed that life sustaining care for the baby is appropriate, active obstetric management is important to ensure the baby is born in the best possible condition. Please refer to the BAPM Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation Framework for Practice (page 13). Consideration should be given antenatal steroids, magnesium sulphate for neuroprotection, tocolysis and in-utero transfer to a tertiary obstetric/ neonatal unit.

Obstetric Management	Yes / No / NA	If Yes, Date / Time Commenced	Signed
Corticosteroids			
Magnesium sulphate			
Tocolysis			
In-utero transfer			

Management of a Baby Born with Signs of Life Who is Not For Active Survival Focused Care

- ☐ Baby should be treated with dignity, respect and love
- ☐ Comfort care should be provided
- ☐ Wrap the baby to keep the baby warm and provide the option of family holding the baby
- ☐ If the family do not wish to see or hold the baby place the baby in an appropriately sized Moses basket in an alternative and private environment

Second Trimester Pregnancy Loss Partogram

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 During Labour and Birth

In a maternity setting, this should be the same as normal care in labour as per trust policy including use of partogram and maternal observations (pages 12 and 13). It is recommended that the woman uses a bedpan whilst using the toilet during the induction process and during labour, especially at earlier gestations.

Adequate analgesia should be offered. All usual modalities should be made available, including epidural at later gestations (when the clotting profile has been confirmed as satisfactory). If intramuscular opiate analgesia is chosen, then diamorphine should be used in preference to pethidine as it provides better analgesia. Fentanyl patient-controlled analgesia (PCA) is also an acceptable choice in pregnancy loss, as there is no concern about accumulation in the baby.

Additional Information
Include any events in labour which require further discussion at postnatal review

Labour and birth summary		
Mode of birth:	Perineum:	Estimated blood loss:
Placental weight g	Birthweight g	Centile:
Born with signs of life: Yes ☐ No ☐	Date of death: NA ☐	Time of death: NA ☐
Seen by doctor when signs of life Yes ☐ No ☐ NA ☐		Seen by same doctor following death Yes ☐ No ☐ NA ☐
Death certified by doctor Yes ☐ No ☐ NA ☐		Doctor's name: NA ☐
Cause of death:		Coroner informed Yes ☐ No ☐ NA ☐

Umbilical Cord

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:

Fetal chromosome analysis

Only send sample of umbilical cord or placental tissue if fetal abnormality, or if requested by cytogenetic dept or if 3rd consecutive miscarriage.

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

Offered Yes ☐ No ☐ N/A ☐
Accepted Yes ☐ No ☐

If cause for death is known then investigations may be omitted.

Placenta

Do not place in formalin until cord sample for chromosomal analysis and swabs for microbiology obtained if required.

Placental swabs obtained

Obtain as soon as possible

Swab from maternal surface of placenta only

Microbiology

Offered Yes ☐ No ☐ N/A ☐
Accepted Yes ☐ No ☐ N/A ☐

Surgical evacuation of placental tissue Yes ☐ No ☐
If yes, was it morbidly adherent? Yes ☐ No ☐

Verbal consent for histopathological examination of the placenta obtained. Preserve in formalin (or other preservative as per local policy) whilst awaiting transport to laboratory ONLY after taking swabs and segment of cord for fetal chromosomal analysis if required	Placental pathology offered: Yes ☐ No ☐ N/A ☐ If Yes Accepted ☐ *(ie gave verbal consent)* Declined ☐

Care of Baby

Individualised where appropriate.

	Yes	No	N/A	Comments	Date	Signature
Identify baby. Use 2 name bands. Attach 1 name band around fetal abdomen if unable to place around limbs. Second identity band alongside baby. State "Baby of [mothers name/mothers hospital number/date, time of birth and hospital].						
Does the mother wish to see/hold her baby immediately?						
Photographs: Discuss and offer memento photographs to be taken. Offer the parents the opportunity to take their own photographs. If taken by Medical Illustration - consent will need to be obtained.	1st offer 2nd offer					
Verbal consent obtained for initial examination for above 16+0.				If consented to see sheet on next page		
Weigh the baby.						
Calculate birth weight centile (if 22+0 weeks or more)						
Discuss personal items: • Hand and foot prints • Name band • Cord clamp • Certificate of loss	1st offer 2nd offer					
Provide the parents with the opportunity to choose clothes and blankets for the baby and to offer to start a memory box with them or equivalent.						
Ask parents if they would like to dress the baby themselves. Dress baby, if gestation appropriate, in appropriately sized clothes. Carefully and respectfully lay the baby in as natural position as possible in a Moses basket.				If for religious or personal reasons, parents do not wish their baby to be dressed use plain white sheets.		

Care of Baby

	Yes	No	N/A	Comments	Date	Signature
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 the opportunity to make an entry into the remembrance book.						
Offer spiritual pastoral care. Ask if they would like their baby to be blessed and inform the hospital chaplain or appropriate religious leader if preferred.				Refer to baby with chosen name, if applicable		
In the event of birth of a multiple pregnancy at the threshold of viability with one surviving baby consider the Butterfly Project (page 18 in the STPL Guideline) neonatalbutterflyproject.org Provide the parents with the Twins Trust leaflet https://twinstrust.org/bereavement						

Clinical Examination of Baby (if 16+0 weeks or greater)

Verbal consent obtained and documented for external examination of baby (page 15)

MEASUREMENTS

Weight _____g

Birth Weight Centile_____

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_____

_____

Abnormal webbing or syndactyly☐

If abnormal describe _____

_____

THUMBS

Number present _____

If not 1+1 please describe_____

_____

Unusual position of fingers ☐

Looks like a finger ☐

If abnormal describe _____

_____

FEET

Normal appearance ☐

Abnormal appearance ☐

If abnormal describe _____

_____

TOES

Number present _____

If not 5+5 please describe_____

_____

Abnormal spacing ☐

If abnormal describe _____

_____

GENITALIA

Anus ☐ Normal ☐

Imperforate ☐ Other ☐

If other please describe

_____

SEX

Male ☐ Female ☐

Ambiguous ☐

EARS

Normal ☐ Low set ☐

Pre-auricular tags ☐ Pre-auricular pits ☐

Posteriorly rotated ☐ If other describe

_____

NECK

Normal ☐ Short ☐

Excess ☐ Cystic mass ☐

/redundant skin (hygroma)

If other describe_____

CHEST

Normal ☐ Long/narrow ☐

Short and broad ☐ Other ☐

Describe _____

ABDOMEN

Normal ☐ Flattened ☐ Distended ☐

Hernia ☐ Omphalocele ☐

Gastroschisis ☐

Clinical Examination of Baby

BACK
Normal ☐ Spina bifida ☐
If spina bifida, level of defect
Scoliosis ☐ Kyphosis ☐ Other ☐
If other describe_____
_____

LIMBS
Length
Normal ☐ Long ☐ Short* ☐
*If 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 Birth

If cause of fetal loss known (e.g. fetal aneuploidy or lethal malformation), further investigations may not be required. This should be discussed with the consultant who has managed the woman antenatally or the Fetal Medicine Unit where appropriate.

Further investigations required? Yes ☐ No ☐

If no, state reason:_____

Offer to All* unless cause known eg fetal aneuploidy, lethal malformation or lead clinician customises further investigations.

Offer to all	Other information	What	Destination	Date	Yes	No
Fetal infection screening		Swab from baby's axilla	Microbiology			
		Swab from maternal surface of placenta	Microbiology			
Maternal serology	TORCH Screen & Parvovirus B19	Maternal blood	Microbiology			
Placental pathology	Recommended even if post mortem examination is declined. Take swabs and cord samples (if required) prior to placing placenta in formalin	Whole placenta and membranes	If less than 16 weeks and no PM – local hospital in Greater Manchester. If greater than 16 weeks Paediatric histopathology, St Mary's Hospital. Alder Hey Hospital for Cheshire and Mersey from 13/40.			
Post mortem	Consent should be taken by a pathologist or a midwife or doctor with appropriate consent training	Copy of maternity notes or complete PM information form				

Selective Investigation (perform only if there is a clinical indication)

Selective investigations	Other information	What	Destination	Date	Yes	No
Kleihauer	At diagnosis **Test in all Rh negative or if history of trauma or clinical suspicion in Rh positive women**	Maternal blood	Blood Transfusion			
If 16+0 weeks or more, external examination of baby	To identify any major fetal abnormalities	External examination				
If clinically suspected maternal infection	If maternal flu like illness Abnormal coloured liquor; or prolonged ruptured membranes	Blood cultures, MSU, high vaginal swab, endocervical swab (inc for Chlamydia spp), throat swab	Microbiology			
If fetal anomaly diagnosed or chromosomal anomaly suspected, or if 3rd consecutive miscarriage (with the exception of isolated neural tube defect which are unlikely to have a genetic cause)	Fetal chromosomes Take 3cm of umbilical cord and place in saline (**not formalin**) for transport. If no identifiable/ retrievable umbilical cord: send 2cm^3 of placenta	3cm of umbilical cord **Do not send more than the required amount of tissue.** (Parents to sign box in umbilical cord section on page 15 of STPL ICP)	Cytogenetics, St Mary's Hospital/ Liverpool Women's Hospital			
If fetal abnormality suspected (with the exception of isolated neural tube defect which are unlikely to have a genetic cause)	Discuss with local clinical genetics, whether fetal genetic examination appropriate	Whole fetus transferred via mortuary	Clinical Genetics, St Mary's Hospital 0161 276 6506/Liverpool Women's Hospital 0151 702 4229			

Selective investigations	Other information	What	Destination	Date	Yes	No
If suspected maternal substance abuse	Needs maternal consent	Urine for cocaine metabolites	Chemical Pathology			
If hydrops fetalis	Anti Ro and La Red cell antibody screen		Immunology Blood Transfusion			
If intracranial haemorrhage (found at post mortem)	Maternal alloimmune antiplatelet antibodies	Blood test from mother and father	Immunology			
If there is no obvious cause **If late fetal loss without PPROM or preterm labour** **If fetal growth restriction** **If abruption**	Maternal thyroid function tests HbA1c	At delivery	Chemical Pathology			
	Lupus anticoagulant Anticardiolipin antibodies Anti-beta2 glycoprotein1, antibodies Factor V Leiden, Prothrombin gene variants	At delivery episode	Immunology			
	Protein C and S, antithrombin	At least 6 weeks postnatal	Haematology			
	Lupus anticoagulant Anticardiolipin antibodies	**If positive on previous test:** repeat at least 12 weeks postnatal	Immunology			

Please note:

Parental chromosomes are not routinely required. They should be obtained **only if**:

- Fetal chromosomal analysis shows an unbalanced translocation
- Fetal chromosome analysis fails with a fetal abnormality on ultrasound or post mortem
- If suggested by the genetics team on the fetal chromosome report

Miscarriage Certification

	Yes	No	Signature
Certificate offered to parents			
Certificate accepted by parents			
MBRRACE notifying officer informed of fetal loss (see table page 24 for reporting criteria)			
Medical form for cremation or burial (under 24 weeks fetal loss) completed and sent to the relevant department as per local policy			

Registration

At gestations under 24 weeks/or where the gestation is not known, babies born with signs of life who subsequently die need to be registered as a birth and death. (see Mode of Birth on page 14) .

Babies born with signs of life should be seen by a doctor at the earliest opportunity, so that in the event of a live birth and subsequent death, a neonatal death certificate may be issued to the mother. A medical certificate of cause of death may only be signed by a registered medical practitioner and cannot be signed by a midwife or nurse. Where a doctor has not witnessed the baby showing signs of life but signs of life have been observed by either the midwife and/or the parents, a doctor must notify the coroner before a neonatal death certificate can be issued.

The coroner must be notified of all babies born with signs of life following a termination of pregnancy.

In such cases where a fetus has died before 24 weeks, but is expelled from its mother after 24 weeks, e.g. delay between diagnosed miscarriage and giving birth, fetal reduction, fetus papyraceus, multiple pregnancy) and its gestation is either known or provable from the stage of development or ultrasound, then the fetus does not have to be registered (RCOG, 2005).

See Coroner's Referral Form in the Second Trimester Pregnancy Loss Guideline (Appendix 2).

	Yes	No	Signature
Coroner's referral required			
If yes date referral sent			
Full name of doctor who has completed referral			
Bereavement Lead and Mortuary informed of referral			
Coroner's approval obtained			
Coroner's release form required			
Coroner's inquest to be held?			

MBRRACE

Deaths to be reported to MBRRACE-UK since 1 January 2013 through the secure online reporting system:

	Yes	No	N/A	Comments	Date	Signature
Notify person responsible for completing MBRRACE form. Nominated individual to complete national Perinatal notification (currently MBRRACE Perinatal Death Surveillance)						
All late fetal losses from 22+0 to 23+6 weeks showing **no** signs of life, irrespective of when the death occurred. Both date of birth and date of confirmation of death should be reported for these cases.						
Early neonatal death: a live born baby (born at 20+0 weeks gestational age or later, or with a weight of 400 gms or more where an accurate estimate of gestation is not available) who died before 7 completed days after birth, should be reported to MBRRACE.						
Terminations of pregnancy - resulting in a pregnancy outcome from 22^{+0} weeks gestation onwards, **plus** any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death.						

Postnatal Care of Mother

	Yes	No	N/A	Comments	Date	Signature
Woman reviewed by bereavement midwife/nurse						
Offer advice regarding expected emotional reactions and difficulties. Provide information about support groups (page 36)				Leaflets given:		
VTE score/risk assessment as per Trust guideline				LMWH to be prescribed if necessary, based on risk factors		
Check FBC depending on blood loss prior to discharge				Review take home medication		
Check Rhesus status and check that anti D has been given				Check whether anti D was given at diagnosis of fetal loss		
If paper medical notes are in use, 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 pregnancy loss				Verbal consent acceptable		
Complete the Bounty suppression form or activate local agreement						
Ensure a senior grade/ consultant obstetrician or gynaecologist reviews the woman prior to discharge						
Discuss postnatal recovery and expectations.						
Discuss and provide contraception of the woman's choice if possible						

Complete Postnatal Discharge

	Yes	No	N/A	Comments	Date	Signature
Discharge woman as per Trust policy						
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

	Yes	No	N/A	Comments	Date	Signature
Does the woman consent to a community midwife visit? (Dependent on local policy, 16 weeks or over)						
If a visit is declined, the community midwives, GP, health visitor, child health should still be notified of the miscarriage to avoid inappropriate contact.				Name of the GP/GP receptionist informed, with date and time.		
If community midwife visit is declined, advise woman to see her own GP.						

GP

	Yes	No	N/A	Comments	Date	Signature
Inform GP by telephone and send the discharge by post to the surgery, **highlighting the fetal loss outcome**.						

Suppression of Lactation

	Yes	No	N/A	Comments	Date	Signature
Discuss suppression of lactation if more than 18 weeks. If accepted give Cabergoline 1 milligram orally. If declined or contraindicated to discuss alternative methods review				Cabergoline contraindicated if allergy to ergot alkaloids, history of puerperal psychosis, pulmonary/ pericardial/retro-peritoneal fibrosis and cardiac valvulopathy. Caution hypertension and pre-eclampsia		

Postnatal Care of Mother

	Yes	No	N/A	Comments	Date	Signature
Ensure that the parents have all the relevant contact details if there are complications. Following discharge options are: • Bereavement Midwife • Community Midwife • Gynae Assessment Unit • Maternity Triage • Consultant's Secretary						
Inform the mother that she is able to come back to spend time with her baby if she wishes. Advise that she should phone the relevant department to arrange to visit 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 birth and the degree of maceration present.		
If paper notes are in use, track the medical notes for all women not consenting to a post mortem to the relevant department (as per local policy)						
Communication of outstanding screening results to patient by screening midwife (as per local policy)				See STPL guideline (Appendix 10)		
Arrange a postnatal follow-up appointment with Consultant Obstetrician/ Gynaecologist after investigation results are anticipated to be received				It may take 12 weeks for a full post mortem report to be received, in the meanwhile remind the woman to make contact with her GP regarding wellbeing.		

Postnatal Care of Mother - PMRT

For pregnancy losses over 22 weeks (only babies with a birthweight over 400gms excluding TOPs), explain the **Perinatal Mortality Review Tool** (PMRT) review process to the parents and record parents' questions in the box below.

	Yes	No	N/A	Comments	Date	Signature
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).						
Inform parents of annual Service of Remembrance						
Arrange a postnatal debrief appointment				It may take 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

Inform parents as to where the baby will be taken once the parents go home.

	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 effects 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.						
If paper notes in use ensure that the relevant information is sent to the pathologist performing the post mortem (as per local policy. This could involve completion of a form or a copy of the maternity notes).						
Prepare baby for transfer. For example, pram or Moses basket						
Attach one name band to the transport container.						
Ask parents if they wish to be accompanied and if they wish to carry the baby or to have baby carried by a health professional						
All appropriate funeral documentation should be clearly identified and accompany the baby.						
Telephone the mortuary to inform them of the transfer.						

Taking a baby home

	Yes	No	N/A	Comments	Date	Signature
There is no legal reason why the parents may not take their baby home.				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 lead on the process to be agreed.		
The baby must be taken home in an appropriate casket or Moses basket. The parents then take responsibility for arranging the funeral if the baby was born with no signs of life, if they wish.						
The means of transport home must be appropriate i.e. private not public transport.						
Completed appropriate documentation as per local policy for releasing baby from ward and refer to local guidance						
Following coroner's referral, a coroners release form needs to be obtained before the baby can be released						

Some hospices offer the use of a cold room facility. This allows the family to stay with the baby and say goodbye in a supportive environment. This is a place where babies can lay at rest after their death until the day of their funeral. Please check your local arrangements. See http://www.neonatalnetwork.co.uk/hospice-care/file/HospiceInformation

Funeral Arrangements

As per local arrangements and gestation	Yes	No	N/A	Comments	Date	Signature
Go through the options available for burial/cremation of their baby. If the parents would like the hospital to help them with the funeral arrangements, refer the parents as per local hospital arrangements. Document arrangements.						
Complete the Medical Form for Cremation or Burial						
If the family choose a hospital burial this Medical Form for Cremation or Burial must be given to the dedicated individual in your Trust ie mortuary or bereavement centre.						
If the family choose to arrange their own funeral the Medical Form for Cremation or Burial is usually given to the family to give to their funeral director of choice, however check your local Trust policy.						
If the baby is to be cremated local documentation must be completed and signed.						
If the parents choose to have a hospital cremation or a private cremation the Medical Form for Cremation or Burial must be sent to the mortuary with the baby.						

Funeral arrangements

Whilst there is no legal requirement to bury or cremate babies who are miscarried <24 weeks gestation, many families will wish to. Parents should be given details of the options available, which may depend on gestation and the contract held with the funeral director and the crematorium, but include hospital cremation, private burial or private cremation. Some hospitals offer both individual cremation and shared cremation. In a shared cremation, several babies are cremated at the same time.

If the parents would like the hospital to help them with the funeral arrangements, refer to local hospital policy. Document what arrangements are likely to be carried out. Complete a certificate for burial or cremation (disposal) and send to the dedicated individuals in your trust i.e. mortuary or bereavement centre. If the family are arranging their own funeral the certificate of disposal should be sent with the family who should be advised to give it to their funeral director.

Funeral Arrangements

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 a hospital cremation is chosen ask the parents what they wish to do with the ashes. If they wish to collect them advise when and where this will occur. If they do not, or if the trust policy is to scatter ashes in a designated place eg baby garden, ask the parents if they wish to know when this will occur. At very early gestations, or if the hospital offers shared cremation only then the parents should be informed that there will not be any individual ashes to collect.

Further advice and information on sensitive disposal of fetal remains can be found in the frequently asked questions section of the Human Tissue Authority website: https://www.hta.gov.uk/faqs/disposal-pregnancy-remains-faqs or from guideline

Follow Up Visit Prompt List

Prior to Consultation

1. Ensure all results are available
2. Notes of any case review are available

Visit date: _____

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

Date of pregnancy loss _____ Baby's name_____ Gestation _____

Counselling offered Yes ☐ No ☐ Already receiving ☐ Other _____

Observations

Blood pressure _____ BMI _____Pulse _____ LMP _____

Investigations	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			

Final Diagnosis

Any other issues to be addressed / referrals / further investigations

Plan for future pregnancy

Who to contact when pregnant	
Antenatal plan of giving birth	

Follow Up Visit Prompt List

General Points Discussed

Pre-pregnancy advice for next pregnancy (see page 13 for events that occurred at birth for discussion)

☐ Smoking
☐ Safe alcohol consumption
☐ Illicit drug use
☐ Folic acid prophylaxis
☐ Contraception
☐ BMI
☐ Psychological wellbeing
☐ Other medication (eg aspirin)

Advise parents that following a second trimester pregnancy loss:

i. Approximately a 7% risk of recurrent second trimester loss
ii. Approximately a 25 - 35% risk of preterm birth

Other medical issues, medications, pre pregnancy medical conditions

Plan for next pregnancy

- ☐ Booking under Consultant Obstetrician
- ☐ Consider whether aspirin or LMWH are indicated
- ☐ Consider cervical length scans depending on presentation and likely cause of miscarriage
- ☐ Offer extra ultrasound scans for reassurance
- ☐ Consider extra precautions for postnatal depression
- ☐ Consider referral to preterm labour clinic for cervical length scans or cervical suture depending on presentation and likely cause of miscarriage. For future pregnancies, consider history-indicated insertion of cervical cerclage and if recurrent second trimester pregnancy loss consider transabdominal cerclage (TAC)
- ☐ If chronic histiocytic intervillositis on placental histology discuss with Rainbow Clinic at St Mary's Hospital or Wythenshawe for commencement of aspirin, LMWH, prednisolone and hydroxychloroquine at 7 weeks gestation after an early viability scan, followed by close ultrasound surveillance.

Following the consultation

Write a letter to the parents with a copy to the GP following this consultation ☐

Consultation performed by

Name _____ Designation: _____

Signature _____ Date: _____

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 & Thursday evenings 8pm to 10pm).
Website: www.arc-uk.org/

Bliss for babies born sick or premature
Family support helpline offering guidance and support for premature and sick babies.
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/

CRADLE
Providing a range of services to support anyone affected by early pregnancy loss
Website: Home | Cradle Charity

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
Website: http://www.lullabytrust.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

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
Website: http://www.uk-sands.org

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

Lighthouse Therapy Service
Post Infant Loss Support Service covering Merseyside
Website: Support Group | Lighthouses Therapy Services

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

SPACE
A Liverpool-based peer support network for those facing miscarriage or infertility
Website: www.thereisspaceforyouhere.com

Liverpool Bereavement Services
Provide 1:1 counselling for people who are struggling to cope with a loss.
Website: https://liverpoolbereavement.com/

Love Jasmine
Supports for families directly affected by the loss of a child providing provide practical, emotional and respite support and promote self-care to improve the emotional wellbeing of the whole family.
Phone 0151 459 4779 (Mon-Fri 930 – 1700)
Or call/text 07566 225 253
Website: https://www.lovejasmine.org.uk/

Parking Permit

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

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:

_____

Greater Manchester and Eastern Cheshire Strategic Clinical Network
Greater Manchester Integrated Care Partnership
4th Floor | 3 Piccadilly Place | Manchester | M1 3BN
www.england.nhs.uk/north-west/gmec-clinical-networks/
www.gmintegratedcare.org.uk

North West Coast Strategic Clinical Network
Vanguard House | Sci-Tech Daresbury | Keckwick Lane | Daresbury | Halton
Warrington | WA4 4AB
https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/