NHS North West

NORTH WEST GUIDELINE

Management of Stillbirth

To be used in association with the North West Management of Stillbirth Integrated Care Pathway V5

To be used from 24+0 weeks gestation

If less than 24+0 weeks please see North West Management of Second Trimester Pregnancy Loss Guideline and ICP.

For TOPFA please see North West Regional Guideline on Termination of Pregnancy for Fetal Abnormality, V1, April 2025.

Guideline produced on behalf of the North West regional maternity team

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

Document Control:

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Compliant With:

RCOG Green-top Guideline No. 55, Care of Late Intrauterine Fetal Death and Stillbirth, October 2024.

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I would particularly like to thank Dr Kate Navaratnam, Consultant in Maternal-Fetal Medicine, Honorary Senior Lecturer at Liverpool Women's Hospital and author of the new North West Management of Termination for Fetal Anomaly Guideline, with whom I worked very closely to separate the guidelines for stillbirth and termination for fetal anomaly, yet ensure alignment of sections common to both.

These guidelines are available to be adopted across the North West (and anywhere else that finds them useful) in order that parents and their families receive compassionate, family centred and high-quality care if they experience this devastating event.

Please note that appendices are geographically orientated and may need editing or localisation.

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Conflict of Interest:
None declared.

The North West Regional Guidelines have been created with experts from the region to provide the best evidence based practice for all our service users. We understand units have their own templates reflecting their individual institutions' governance requirements however when transferring the guideline the authorship, issue date, content and review date must remain the same.
In addition, deviations from practice recommended in the regional guideline should be discussed with the Regional Guideline Group.

NHS North West

Contents

1 Summary

The stillbirth of a baby is traumatic for the parents, who deserve to be cared for with empathy and compassion. Stillbirth can be traumatic for everyone involved, including healthcare professionals. Care provided and your role as supporter, counsellor, friend, advocate, carer and clinician is pivotal to the family's experience and subsequent memories of this time. What we do for families during this time will last a lifetime so it is important that we get it right. This guideline and associated Integrated Care Pathway align with the principles of the Sands National Bereavement Care Pathway[1]. We use the terms 'woman' and 'women' but the guideline also applies to people who do not identify as women but are pregnant or have given birth.

2 Purpose

The purpose of this guideline is to help healthcare professionals to deliver optimal care for women and their families when they experience stillbirth.

If caring for families who are undergoing termination of pregnancy for fetal anomaly at any gestation, please see North West Management of Termination for Fetal Anomaly Guideline, version 1, April 2025.

3 Scope

This guideline is available to be adopted across the North West (and anywhere else that may find this useful) in order that parents and their families receive compassionate and high-quality care if they experience stillbirth. Please note that appendices are geographically orientated and may need editing for localisation.

4 Responsibilities

Midwives, obstetricians, health care assistants, counsellors, perinatal histopathologists, mortuary staff, bereavement teams.

5 Guidance

5.1 Introduction

Stillbirth occurs in approximately 1 in 250 babies in the UK. Stillbirth is a devastating event with enduring psychosocial consequences for parents, including anxiety and depression, guilt, complicated grief, social isolation and relationship breakdown[2].

The definition of stillbirth 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)[3]
"*a child which has issued forth from its mother after the 24th week of pregnancy and which did not at any time breathe or show any other signs of life*".

Late intrauterine fetal death (IUFD) refers to babies with no signs of life in utero after 24+0 completed weeks of pregnancy[3].

Stillbirth rates in the UK reduced by 21% from 4.20 per 1000 total births in 2013 to 3.33 per 1000 total births in 2020. The overall reduction in the stillbirth rate was mainly due to a reduction in the rate of term stillbirths by one-fifth (19%). The stillbirth rate increased to 3.54 per 1000 total births in 2021 then decreased to 3.35 per 1000 total births in 2022. Although a welcome reduction from the previous year, the UK continues to have an above average rate of stillbirth when compared to other high-income countries. Babies born to women living in the most deprived areas are twice as likely to be stillborn. Babies of Black ethnicity remain more than twice as likely to be stillborn compared with babies of White ethnicity (Black: 6.19 per 1,000 total births; White: 2.99 per 1,000 total births).

Parents should be advised that with full investigation (including post mortem and placental histology) a possible or probable cause can be found in up to 75% of late intrauterine fetal deaths. Placental issues are the most common cause of death. Other causes include infection, pre-eclampsia, fetal growth restriction, congenital abnormalities and complications of multiple pregnancies[4,5].

A Sands (Stillbirth and neonatal death charity) report noted "Poor or insensitive care at this traumatic time adds significantly to parents' distress. Good care should be universal and should not depend on where a mother happens to live or be cared for."[6] This guideline is written to support an integrated care pathway tool to enable staff to provide optimal and compassionate care to families from the point of diagnosis of intrauterine fetal death and to reduce variation in bereavement care. This guideline has been written by a multidisciplinary team of professionals working in maternity units across the North West. It draws largely on the Royal College of Obstetricians and Gynaecologists (RCOG) Green Top Guideline No.55 Late Intrauterine Fetal Death and Stillbirth, published in 2010 and updated in 2024[7,8].

The National Bereavement Care Pathway, led by a multi-agency core group of baby loss charities and professional bodies, includes good practice recommendations for optimal care of bereaved parents. This guideline and integrated care pathway align with the National Bereavement Care Pathway https://nbcpathway.org.uk/pathways/stillbirth-bereavement-care-pathway[1].

5.2 Diagnosis and Immediate Care

When an intrauterine fetal death (IUFD) is suspected this **must** be confirmed by two-dimensional ultrasound at the earliest opportunity. If suspected in the community setting then the mother should be immediately referred to hospital for confirmation.

The optimal method is an ultrasound scan performed by trained sonographers. However, out of normal working hours a practitioner with appropriate training may use a portable ultrasound machine. The fetal chest should be imaged in the transverse to identify a 4-chamber view of the heart. Colour-flow Doppler is useful to verify the absence of heart activity. It is best practice to obtain a second opinion from a suitably trained person, although it is recognised that this may not always be possible in emergency situations. Whenever possible, sonographers should explain what they are doing during the ultrasound scan as long silences may be very hard for parents. Ask the parents if they wish to see the screen. If the sonographer needs time to concentrate, it may be helpful to say "I am going to be quiet for a moment so that I can concentrate on the screen." Staff should be aware that parents are often highly sensitive to non-verbal messages and body language.

Breaking Bad News

It is recommended that clinicians should undergo training in breaking bad news. This is available from the National Bereavement Care Pathway [NBCP] e-learning programme www.elfh.org.uk/programmes/national-bereavement-care-pathway/ and the Sands (stillbirth and neonatal death society) training programme https://training.sands.org.uk/.

If the woman is unaccompanied, an immediate offer should be made to call her partner, or chosen relative or friend. If English is not the first language of a family, a professional interpreter (ideally face-to-face) should be used. A warning must be given to the interpreter as to the content of the conversation. A clear, sensitive and honest explanation should be given by experienced staff, avoiding jargon. The Sands leaflet 'Sensitive and effective communication' gives some helpful advice: https://www.sands.org.uk/sites/default/files/Sensitive%20and%20Effective%20Communication.pdf.

Parents who have experienced baby loss report that indifferent attitudes from doctors and midwives and insensitive remarks and actions are remembered for a long time after the loss of their baby. Conversely, showing empathy and a few thoughtful, heartfelt, caring words can last a lifetime.

Practice Points For Sharing Bad News

- The discussion should take place in a suitable environment, ensuring privacy.
- Partners should be included in all discussions, unless the mother declines.
- Plenty of time must be allowed when breaking the news of the baby's death.
- Make eye contact and use warm body language.
- Offer refreshments to the family.

Below is an example statement which could be used upon confirmation of intrauterine fetal death with ultrasound:

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

Discussions should be culturally sensitive and should aim to support maternal/parental choice. Staff should be patient and sensitive to individual needs, particularly with neurodiversity or disability.

Following the diagnosis and confirmation of an IUFD the parents must be given time to absorb and accept this news. Staff should be aware of the range of reactions that parents may have when receiving this news and offer emotional support. Many parents are surprised and shocked that they will still have to go through labour. They may also be surprised that they may go home whilst awaiting birth and that there may be a delay in giving birth to their baby who has died. It is vital that the parents are fully informed. Some parents will want to go home to see other family members before labour; others will want the induction process to commence as soon as possible. If the mother goes home, the possibility of passive movements should be discussed with her and 24-hour contact numbers should be given. Questions should be welcomed and encouraged. Naturally, parents want to know why their baby has died. This may not be known at this stage, but parents must be assured that it is not their fault and that investigations may be helpful.

Parents should be offered written information to supplement discussions, such as the RCOG patient information leaflet "When your baby dies before birth - information for you"[9] or "When a baby dies before labour begins" from Sands[10] **(Appendix 1)**.

5.3 Psychological Support

The death of a baby can be associated with short term and chronic anxiety and depression not only in the mothers but also the father or co-parent, siblings and other family members. Feelings of grief and loss (bereavement reactions) are very common and expected. The bereavement midwives should be informed at the earliest opportunity. 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. All women who experience an IUFD are at risk of depression, but those with previous psychiatric disease or of a vulnerable social group are at particular risk.

Place of Care

Whilst in hospital the parents should be cared for in a suitably furnished bereavement suite, both throughout labour and the postnatal stay with close access to continuous midwifery/obstetric care. The partner/family should be able to remain with the mother as long as she wishes. Some maternal conditions may require higher level care on the Labour Ward (see 5.6 Timing of Birth).

Pastoral and Spiritual Care

Health care professionals caring for grieving families should ask if there are any cultural or religious customs which are important to the family and should ensure that these needs are supported wherever possible. Parents may want the opportunity to see their own religious leader or a member of Pastoral Care Chaplaincy Services. This should be facilitated by the maternity unit staff and offered to all families even if they do not have a specific faith.

For more information on religious customs see https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2017/06/NWNODN-Religious-Practices-.pdf. If caring for a Jewish family please see https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2022/10/GMEC-Miscarriage-or-stillbirth-for-Jewish-Parents-SOP-_130922.docx, published by the Jewish Community in Manchester, together with Misaskim, Tommy's and Manchester University Foundation Trust in 2022.

Some Trusts hold an annual multi-faith Remembrance Service, which parents should be informed about and may wish to attend. See page 29 for a list of support organisations and groups.

5.4 Multiple Pregnancies

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.

Clinicians should appreciate the complexity and mixed emotions of couples who experience co-twin demise or selective reduction of one fetus with a surviving twin or higher order multiple. They will require support throughout the remainder of the pregnancy and birth as well as bereavement care. Parents want to talk about the baby who has died and to acknowledge that they were twins or a higher order multiple. Some parents may wish to take photographs of the babies together so this should be discussed and offered.

The Butterfly Project has produced materials to educate staff and improve the experience of families who have single fetal demise in a multiple pregnancy. The resources can be found at the following link https://www.neonatalbutterflyproject.org/resources/.

The timing and mode of birth for multiple pregnancies in the case of single fetal demise will depend on chorionicity, gestation, the presentation of the fetuses and the wellbeing of the surviving baby/babies. Specialist advice should be sought in complex cases (e.g. local multiple pregnancy lead). See patient information in **Appendix 1**.

The Butterfly Project: Supporting parents with the death of a baby in a multiple pregnancy

Parents who have suffered a bereavement from a multiple pregnancy face the difficult challenge of dealing with the bereavement, while often simultaneously feeling anxious about the prognosis for surviving multiples. They differ from parents who have lost a singleton in many ways, but one important difference is that parents who have lost a twin born prematurely often remain in hospital for weeks or months while the surviving twin is cared for on the neonatal unit. Staff attitudes, behaviours and actions have a huge impact on parents both in the short and longer term. Generally, parents appreciate when staff acknowledge that a surviving baby is a twin, and value the importance of knowing about the circumstance of the loss (e.g. when did it occur) as well as the name of the baby who died.

The two concepts developed by the Neonatal Research Network are:

- A small sticker of a butterfly that can be put on the front of the mother's notes, including hand held notes, where the loss happens before birth. Where the loss happens after birth the butterfly could be placed on the medical notes of the surviving twin. Please check with your hospital that this is acceptable.

- A butterfly symbol that is placed inside of, or next to the incubator or cot of any surviving babies. Some parents may like to write the name of the baby who died on the card. Remember to individualise care – some parents may not wish for this.

For further reading see **Appendix 2**

5.5 Management of Birth

This section is designed to assist midwives and obstetricians in the management of labour and birth when there is an IUFD and should be implemented once a robust diagnosis has been confirmed.

Over 90% of women in this situation will spontaneously labour within 3 weeks of the IUFD[11]. Problems related to delayed birth include intrauterine infection if the membranes are ruptured. There is a 10% chance of maternal disseminated intravascular coagulation (DIC) within 4 weeks from the date of fetal death and an increasing chance thereafter[12,13].

The diagnosis of IUFD is made in some women when they present in labour. Whilst vaginal birth is suitable for most women, caesarean section may need to be considered for some. There are also certain clinical situations where the maternal medical condition will necessitate expediting the birth (see 5.6 Timing of Birth).

5.6 Timing of Birth

At Presentation

Take full blood count (FBC), clotting screen, group and save and **Kleihauer (irrespective of maternal blood group as this is to assess for feto-maternal haemorrhage)**. As there may have been feto-maternal haemorrhage, if the mother is Rhesus D negative and the fetus known to be Rhesus positive or the fetal Rhesus status is unknown, 1500iu of Anti-D should be administered IM. The Kleihauer should be repeated after birth for Rhesus negative women with a positive or unknown fetal Rhesus D status to determine whether a further dose of anti D is required[14].

Urgent birth is required if there is sepsis, abruption/antepartum haemorrhage (APH) or severe pre-eclampsia.

In these conditions it may be more appropriate for the woman to be cared for on the Labour Ward to monitor closely for any signs of deterioration, elevated early warning score and to facilitate early escalation of concerns.

The mode of birth and method of induction of labour should customised to the presenting condition and other patient factors including past obstetric history, past medical history and maternal preference. Clinicians should facilitate informed choice, using the BRAIN (benefits, risks, alternatives, intuition, nothing) decision support tool (see ICP page 2).

If the above conditions have been excluded then a senior clinician should discuss the timing and the process with the mother. Vaginal birth is the recommended mode of birth for most women as this is associated with less morbidity and will have fewer implications for future birth than a caesarean section. However, a caesarean birth may need to be considered for some women due to past obstetric, medical or surgical history as well as emotional and psychological factors and maternal choice. If aiming for a vaginal birth the mother should be offered a choice of induction of labour or expectant management. Induction of labour leads to vaginal birth within 24 hours in up to 90% of women[15]. The majority of parents with a singleton IUFD opt to induce labour to expedite birth. If the mother chooses the latter option, then arrangements for review will need to be made.

If birth is delayed >48 hours repeat FBC and clotting screen twice weekly. Also advise that if expectant management is chosen, the value of some information from post mortem may be reduced and the appearance of the baby may deteriorate.

All mothers should be given a 24-hour contact number for information and support if they are managed as an outpatient for any time between diagnosis and birth. Information should be provided about signs/symptoms to be aware of which should prompt action/return to hospital.

Written or verbal consent for induction of labour should be obtained in line with Trust guidance prior to commencing the induction process.

5.7 Drug Information

Pre-induction

Mifepristone is an anti-progestogenic steroid used as pre-treatment. It facilitates uterine response to subsequent administration of a prostaglandin.

Contraindications include uncontrolled or severe asthma, chronic adrenal failure and acute porphyria.

Cautions include asthma, risk factors for cardiovascular disease, prosthetic heart valves or endocarditis and haemorrhagic disorders.

A single dose 200 milligram oral mifepristone is given and if the mother wishes, she should be allowed home wherever possible. The interval between administration of mifepristone and misoprostol can be 0 to 48 hours.

The use of a combination of mifepristone and misoprostol increases the chance of vaginal birth and reduces the number of doses of misoprostol required when compared to the use of misoprostol only[16,17].

Induction

Misoprostol (prostaglandin E1) is usually used for induction of labour in late IUFD.

Cautions – inflammatory bowel disease, conditions that are exacerbated by hypotension (e.g. cerebrovascular or cardiovascular disease).

Side effects include fever, nausea, vomiting, abdominal cramping and diarrhoea. **These are less common if the tablets are given vaginally**.

Serious complications, including uterine rupture and major haemorrhage are rare.

Unscarred uterus: No history of caesarean section, myomectomy or other scar

Mifepristone 200 milligram single dose followed by misoprostol 0-48 hours later.

An interval of 24hrs is recommended between mifepristone and misoprostol but this can be 0-48hrs dependent on individual circumstances.

A vaginal assessment should be performed prior to commencing oral or vaginal misoprostol. In women with a favourable cervix or in early labour, amniotomy followed by oxytocin infusion could be considered for induction or augmentation of labour.

In women with an unfavourable cervix misoprostol should be administered.

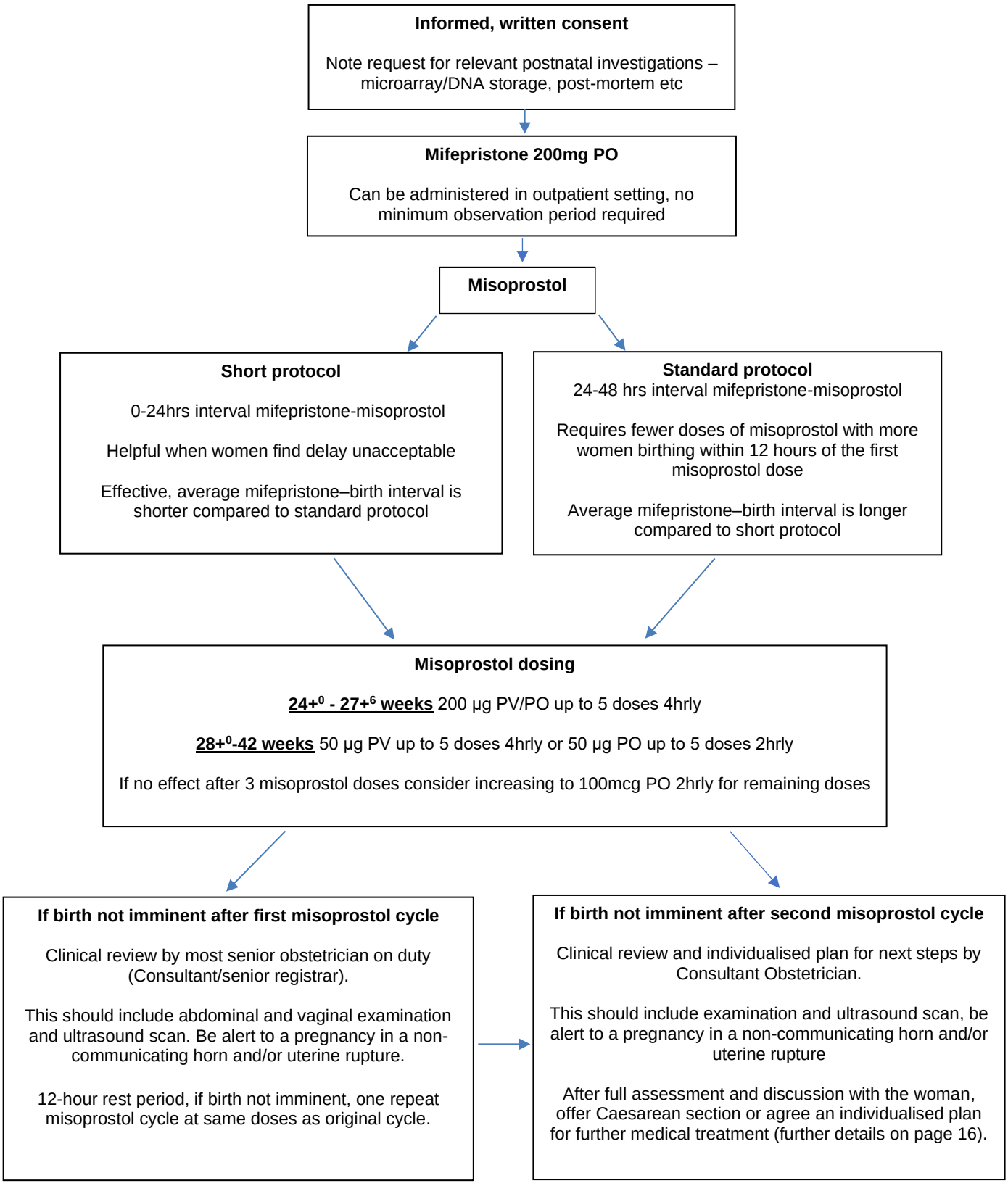
The dosage of misoprostol to be administered will depend on the gestation at which the IUFD occurred (see table below[18]).

Misoprostol is typically available as a 200 microgram scored tablet.

100 microgram doses can be obtained by dividing a 200 microgram tablet into two halves using a pill cutter. Similarly, 50 micrograms can be obtained by dividing the ½ tablet into 2 (i.e. ¼ tablet). It is recommended that the pill cutter is used for accurate division.

Unscarred uterus			
Gestation	**Medication**	**Dose**	**Comments**
Day 1 24-42 weeks	Mifepristone	200 milligrams single dose	PO
0-48 hrs later 24+0 to 27+6 weeks	Misoprostol	200 micrograms PV/PO 4 hourly (5 doses)	PV dose recommended due to lower incidence of side effects.
0-48 hrs later 28+0 to 42 weeks	Misoprostol	50 micrograms PV 4 hourly (5 doses) or 50 micrograms PO 2 hourly (5 doses)	PV dose recommended. If no response after 3 doses, consider increasing to 100mcg PO 2 hourly for the remaining doses.

Unscarred Uterus



Women with a scarred uterus: One previous lower segment caesarean section

A Consultant Obstetrician should discuss with the woman the risks and benefits of induction of labour and take into account her preferences.

Mifepristone 200 milligram single dose orally followed by misoprostol after 0-48 hours. An interval of at least 24hrs is recommended before giving misoprostol as this reduces the dose of misoprostol required. The woman should be given the option of staying in hospital or going home for 24-48 hours. She should return if she has any concerns or signs of labour. If nothing happens overnight, she should be asked to return the following day.

24-48 hours later, misoprostol can be considered for induction of labour in women with one previous LSCS and an IUFD. The RCOG Green-top Guidance on Management of Stillbirth reports insufficient evidence to recommend a specific induction regime for women who have had previous caesarean section[8]. The North West guideline development group recommend the doses in the table below.

If 28 weeks or more, a mechanical method such as cervical ripening balloon or Dilapan can be offered as an alternative to misoprostol as this may have a lower risk of uterine rupture. However, ARM and oxytocin are likely to be required after the balloon/Dilapan is removed. If the cervix is favourable then induction by amniotomy and oxytocin can be offered to women with one previous LSCS after discussion with the Consultant.

Women with two or more previous lower segment caesarean sections:

Women with two or more lower segment caesarean births should be advised that the safety of induction of labour is unknown, therefore greater caution is advised and mode of birth should be discussed on an individual basis with a Consultant Obstetrician. If, after counselling, the woman opts for induction of labour then the protocol above is advised. If the woman presents in labour and wishes a vaginal birth this should be supported if there are no contraindications. The woman should be monitored carefully throughout her labour for signs of uterine rupture (see page 17). If the woman opts for Caesarean section, her choice should be supported.

Women with a previous classical or other atypical uterine scar, or previous uterine rupture:

Vaginal birth is not recommended for women with a previous uterine rupture or a previous classical or other atypical incision (J, inverted T or myomectomy with breach of the uterine cavity). Caesarean section is recommended.

Scarred uterus			
Gestation	**Medication/Agent**	**Dose**	**Comments**
Day 1 24-42 weeks	Mifepristone	200 milligrams single dose	PO (can be managed as an outpatient if the woman wishes)
24-48hrs later 24-27+6 weeks	Misoprostol	100 micrograms PV / PO 4 hourly (5 doses)	PV recommended as lower incidence of side effects.
24-48 hrs later 28+0-42 weeks	Cervical ripening balloon / Dilapan **OR** Misoprostol	Single use 50 micrograms PV 4 hourly / PO 2 hourly (5 doses)	CRB in for 12 hours Dilapan 12-15 hours If no response after 3 doses PV 4 hourly, consider giving the remaining doses PO 2 hourly.

Management of women when there is no response to the first course of misoprostol (5 doses):

There is very limited evidence on further medical management if birth does not occur after misoprostol treatment. The mother should have a bedside review by the most senior obstetrician on duty (ST6-7 or Consultant on call). This should include a physical examination and an ultrasound scan to ensure the fetus is intra-uterine, rule out a uterine rupture or a pregnancy in a non-communicating horn. Where there are no concerns identified, a 12-hour prostaglandin rest period should be recommended, prior to beginning a second misoprostol cycle of 5 doses at the same dose.

Further caution is advised for women who have not birthed following the second misoprostol cycle with a further full clinical assessment by the Consultant Obstetrician, including an ultrasound scan. If no concerns are identified, the Consultant Obstetrician should have an individualised discussion with the woman about further options which include Caesarean section, further medical management with prostaglandins and/or oxytocin where the woman would prefer to avoid surgery.

In Liverpool Women's Hospital and other units within Cheshire and Mersey, carboprost 250 mcg IM 3 hourly (up to 8 doses) has been used where mifepristone/misoprostol management has been unsuccessful. Carboprost is resistant to enzymatic degradation and has improved smooth muscle activation and longer duration of action than misoprostol, but also has associated gastrointestinal side effects which should be discussed with the woman if this option is considered.

During a 6-year period at LWH (2014 – 2020), 10 women received carboprost (including 3 women with previous lower-segment caesarean section) during induction at 16+0 – 32+4 weeks after two cycles of misoprostol, all subsequently achieved a vaginal birth with a mean of 2.6 doses of carboprost (carboprost – birth time of <8 hours) and no complications.

Scarred Uterus

Caesarean section is advised for women with previous classical, J or inverted T incision, other atypical uterine incision or previous uterine rupture.

Induction of labour or caesarean section are reasonable options for women with ≥2 lower segment caesarean sections, after individualised counselling by a consultant obstetrician and informed written consent.

Mifepristone 200mg PO
Can be administered in outpatient setting, no minimum observation period required

Short protocol *acceptable for scarred uterus
0-24hrs interval mifepristone-misoprostol/mechanical method

Helpful when women find delay unacceptable and shown to have shorter mifepristone-birth interval

Standard protocol
24-48 hrs interval mifepristone-misoprostol/mechanical method

Average mifepristone–birth interval may be longer, but where misoprostol is subsequently used, fewer doses may be required

Misoprostol is appropriate for most women with a lower segment uterine scar.

Cervical ripening method may reduce chance of uterine rupture compared to prostaglandins for women with uterine scar undergoing term IOL.
≥28+0 weeks discuss cervical ripening balloon or Dilapan with woman and consider if feasible to insert. A balloon should remain for up to 12 hrs, Dilapan 12-15 hours. Oxytocin is likely to be required after ARM.

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Cervical ripening method may reduce chance of uterine rupture compared to prostaglandins for women with uterine scar undergoing term IOL.
≥28+0 weeks discuss cervical ripening balloon or Dilapan with woman and consider if feasible to insert. A balloon should remain for up to 12 hrs, Dilapan 12-15 hours. Oxytocin is likely to be required after ARM.

Misoprostol dosing

$24+^{0}$ – $27+^{6}$ weeks 100 µg PV/PO up to 5 doses 4hrly

$28+^{0}$ – 42 weeks 50 µg PV up to 5 doses 4hrly or 50 µg PO up to 5 doses 2hrly

If no effect after 3 PV misoprostol doses, consider giving the remaining doses PO 2 hourly

If birth not imminent after first misoprostol cycle

Clinical review by most senior obstetrician on duty (Consultant/senior registrar).

This should include abdominal and vaginal examination and ultrasound scan. Be alert to a pregnancy in a non-communicating horn and/or uterine rupture.

12-hour rest period, if birth not imminent, one repeat misoprostol cycle at same doses as original cycle.

If birth not imminent after second misoprostol cycle

Clinical review and individualised plan for next steps by Consultant Obstetrician.

This should include examination and ultrasound scan, be alert to a pregnancy in a non-communicating horn/uterine rupture

After full assessment and discussion with the woman, offer Caesarean section or agree an individualised plan for further medication (further details guideline p16).

5.8 Care in Labour

Women should be admitted to a birthing room where their emotional and practical needs can be taken into account without compromising their safety. Care in labour should be by an experienced midwife. Ideally one to one care should be facilitated for the first 24 hours to support the mother and the family, though it is recognised that this may not always be possible at times of high activity in the maternity unit. A Consultant Obstetrician should be made aware of the mother's admission.

Birth choices remain as for all women in labour and the woman's birth plan should be reviewed with her. Where medically appropriate, women should be offered the option of using a birthing pool[19]. Decision support aids such as BRAIN (Benefits, Risks, Alternatives, Intuition, Nothing) can help women to make informed birthing choices. https://www.pregnancy.com.au/wp-content/uploads/2020/03/Brain-handout.pdf

Blood tests including full blood count (FBC), clotting screen, and group and save should be performed. Women with sepsis should be treated with intravenous broad-spectrum antibiotics as per Trust guidelines, including cover for chlamydia (if clinically high risk) after sepsis screening investigations have been performed.

In women with a uterine scar, staff should be vigilant to clinical features that may suggest scar dehiscence/rupture: maternal tachycardia, atypical pain, vaginal bleeding, haematuria and maternal collapse. The strength, length and frequency of contractions should be monitored by palpation, with assessment of maternal wellbeing and behaviour. A partogram should be completed to identify trends or concerns and facilitate timely escalation (see pregnancy loss partogram in the ICP, pages 8 & 9).

Pain Relief

Ensure the woman has adequate labour analgesia. Offer the opportunity to speak to the obstetric anaesthetist to discuss analgesic options. All usual modalities should be made available, including regional analgesia and patient-controlled analgesia, taking into account any specific contraindications for each woman. Assessment for disseminated intravascular coagulopathy (DIC) and sepsis should be undertaken before administering regional analgesia.

If patient-controlled analgesia is chosen, fentanyl may be more appropriate than remifentanil. If an intramuscular opiate analgesia is chosen, then diamorphine should be used in preference to pethidine as it is more effective.

Group B Streptococcus

Women with IUFD and Group B Streptococcal (GBS) colonisation of the vagina do not require antibiotic prophylaxis in labour.

Management of third stage

The third stage should be managed in accordance with local guidance.

5.9 Care of Baby

Each family's individual and cultural needs should be identified and accommodated.

The baby should be weighed and the birth weight centile calculated and documented.

Contact with baby

Seeing and spending time with their baby is valuable for the parents. Some parents may wish to see and hold their baby immediately after birth, others may prefer to wait; their decision should be respected. It may be necessary to prepare parents about their baby's appearance if death occurred some time before the birth. Parents are free to change their minds and can ask to see their baby whenever they feel ready. Parents may wish other family members to be given opportunity to see and/or hold their baby. Some units offer families the use of a pram if they wish to take their baby for a walk.

Parents should be offered the use of the cooling cot to maintain baby's skin condition. The use of 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. https://cuddlecot.com/cuddlecot/

Mementos

Mementos should be offered and obtained once the parent's verbal consent has been given. These may include a lock of hair or hand and foot prints, cord clamp, tape measure used to measure baby, cot card, and identity band. Most parents welcome these tokens and they can be presented in memory boxes. Many charities offer memory boxes (for example 4Louis, Sands). Parents may wish to keep the linen from the incubator or cot and the clothes baby was wearing.

If photographs are taken, these should be stored as per Trust guidelines. If mementos and/or photographs are requested but not taken home by parents these can be stored in the hospital records should the parents wish to access them at a later date.

Photographs of baby

Photographs of the baby are valuable and can be taken with the parents' own camera or with the hospital digital camera. If there is a multiple birth, photographs of the babies may be taken together and/or separately. Suggest different photos including family groups, photos of hands and feet and with baby dressed and undressed.

Taking photographs with the hospital digital camera requires parental verbal consent. Similarly, verbal or written consent may be required for photographs to be taken by medical photography (consult local Trust policy). Identification of the start and end of a series of photographs must be performed. An additional option is http://www.remembermybaby.org.uk, a charity with volunteer professional photographers who photograph babies for parents losing their baby before, during or shortly after birth.

5.10 Investigations

Families report three reasons why they have investigations[20]. Firstly, to find out why their baby died and to allow their grief to progress; secondly, to find out useful information for subsequent pregnancies and finally for research to prevent stillbirths in the future.

Finding a cause may potentially influence the care offered in a subsequent pregnancy. This is essential as women who experience one stillbirth are at a two to ten-fold increased risk of stillbirth in subsequent pregnancies so clinicians need information to develop appropriate management plans to reduce the chance of recurrence. Parents should be advised that with full investigation (including post mortem and placental histology) a possible or probable cause can be found in up to three-quarters of late intrauterine fetal death. Under-investigation impedes efforts at gaining an accurate diagnosis[21]. Unfocused investigation could yield results which were not contributory to the death, thus clinicians should take a detailed history which should guide the investigations offered to the family. Parents should be informed that an abnormal test result is not necessarily related to the late IUFD; clinical correlation is required. Not all investigations are required to be taken at birth. Further tests might be indicated following the results of the post mortem examination and placental histology.

Where there is a fetal malformation and the cause of death is known, further investigations may not be necessary. Advice should be requested from the woman's named Consultant or Consultant on call.

The investigations most likely to give useful information are:

1. post mortem
2. placental histology
3. fetal chromosomal analysis
4. antiphospholipid antibodies[22]

A full thrombophilia screen is no longer indicated for all women at birth. See British Society for Haematology guideline, 2022.
https://b-s-h.org.uk/guidelines/guidelines/guidelines-for-thrombophilia-testing [23]

Thrombophilia screening should be performed selectively, only once the placental pathology report is received. See Placental Pathology Tool, developed by the International Rainbow Clinic Network, 2025.
Placental_Pathology_Tool_Version_1.0 April 25.pptx[24]

For further information see 5.15 Follow Up Visit, page 27.

Offer the following investigations to all women if cause unknown:

1. Kleihauer to identify feto-maternal haemorrhage

Ideally taken as early as possible after presentation, to identify a large feto-maternal haemorrhage that preceded the IUFD. This is important for all women, not only women who are Rhesus negative. If there is a large feto-maternal haemorrhage, repeat the Kleihauer after birth if the woman is Rhesus negative and the fetal Rhesus status is positive or unknown, to guide anti D dosing.

2. External examination of the baby

This should be performed by the midwife and in cases of difficulty or suspected abnormality should be confirmed by a neonatologist or geneticist. See page 11 in the Integrated Care Pathway for verbal consent.

3. Screen for fetal infections

- Maternal viral serology for toxoplasma, rubella, cytomegalovirus, herpes
- Syphilis serology if not screened at booking
- Parvovirus B19 (especially if hydrops)
- Obtain a swab from the baby's axilla
- Placental swabs:
    - You may need two people for the procedure
    - Lay the placenta on a clean surface on the maternal surface
    - Choose an area of about 3x3cm away from the umbilical cord insertion
    - Clean this with an alcohol wipe
    - Lift up the amnion with a pair of sterile forceps. The amnion should be thin and semi-transparent
    - Incise the amnion with a sterile scalpel
    - Once incised the amnion will peel away from the chorion to expose a tented gap on the fetal surface
    - Swab in this gap between the amnion and chorion with a sterile swab

4. Post mortem examination by an experienced perinatal pathologist

This requires informed written consent from an appropriately trained individual. It can be a full post mortem, when all organs are examined or limited to specific locations e.g. head, chest or abdomen. The parents should be provided with a post mortem patient information leaflet such as Deciding about a post mortem[25]. The parents should have the opportunity to discuss their options. If a post mortem is accepted, send the signed consent form and a completed perinatal hospital post mortem referral form (maternal details, history, reason for PM). See **Appendix 3.**

5. Placental examination by an experienced perinatal pathologist

Placental pathology is recommended even if post mortem examination is declined. **Placental swabs and cord samples should be taken prior to placing the placenta in formalin or other preservative as per local policy.** If the placenta cannot be fixed in formalin, it should be refrigerated and sent to the laboratory at the earliest opportunity. Report all infectious agents to the pathologist (for example coronavirus, hepatitis, HIV). See **Appendix 4.**

The following selective investigations should only be offered if there is a clinical indication:

1. Infection screening

If the mother at presentation has fever, flu-like symptoms, abnormal liquor (purulent or offensive) or prolonged ruptured membranes, assess for maternal bacterial infection including listeria monocytogenes and chlamydia species:

- FBC, CRP
- Lactate
- Blood cultures
- MSSU
- HVS and endocervical swabs
- Throat swabs (influenza and coronavirus)

2. If there is no obvious cause

- Bile acids
- HbA1c
- Random glucose
- Thyroid function

3. Fetal chromosome analysis

Fetal chromosome testing should be offered for all babies who are stillborn. This may be especially important for babies with known physical abnormalities on ultrasound scan, where prenatal testing has not been performed, or when abnormalities are noted unexpectedly at birth. A small 3cm segment of umbilical cord should be sent to the North West Genomic Laboratory Hub for a microarray. It is not necessary to send a maternal blood sample with the umbilical cord segment following a stillbirth.

Parents who experience a stillbirth after receiving a high chance result for aneuploidy screening should be also be offered fetal chromosome testing but the sample will be for QF-PCR analysis, not a microarray.

Take 3cm of umbilical cord and place in saline for transport. Written consent should be obtained from the mother in the ICP or if having a post mortem section 6 of the **Post Mortem Consent Form** in **Appendix 3**. The statement box *"It is the referring clinician's responsibility to ensure that the patient/carer knows the purpose of the test and that the sample may be stored for future diagnostic tests*" should be completed.

Do not send cord samples for fetal sexing. See **Cytogenetic Testing** information in **Appendix 5** for full referral criteria. St Mary's Hospital 0161 276 6553, Liverpool Women's Hospital 0151 702 4229.

4. If history suggests maternal substance misuse

- Maternal urine for cocaine metabolites (maternal consent required)

5. If hydrops fetalis is present

- Red cell antibody screen
- Maternal anti-Ro (SSA) and anti-La (SSB) antibodies
- Post mortem
- Clinical genetic examination (even if post mortem declined)
- Skeletal survey (even if post mortem declined)
- Placental histology (even if post mortem declined)

6. Parental chromosomes should be obtained only if

- Initial chromosomal analysis shows an unbalanced translocation
- If fetal chromosomal analysis fails with a high-risk history (e.g. fetal abnormality, previous unexplained stillbirth or recurrent miscarriage)

5.11 Stillbirth Certification

Coroners do not have jurisdiction over stillbirths as by definition there has not been a life or death. A coroner's referral must only be made for a stillbirth when the birth was unattended, where the circumstances are suspicious or where there is doubt as to whether the baby was born alive. **There is no requirement to refer stillbirths to the Medical Examiner.** See Chief Coroner's Guidance No. 45 Stillbirth and Live Birth Following Termination of Pregnancy (February 2023)[26]. https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-45-stillbirth-and-live-birth-following-termination-of-pregnancy/

Legally, a medical certificate of stillbirth should be issued in all cases of stillbirth from 24+0 weeks gestation by a doctor or midwife who was present at the birth of the baby or has 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. Reference to the ReCoDe classification (Relevant Condition at Death) is a useful guide to ensuring that accurate information is recorded here (see Appendix 6). If the cause of stillbirth is not known, write unexplained.

Give the stillbirth certificate to the parents to take to the registrar of births and deaths (see local policy as the stillbirth certificate may need to be emailed to the registry office or Trust bereavement office).

The parents are responsible by law for registering the stillbirth within 42 days. In extenuating circumstances (such as maternal death), the responsibility for registration may be delegated to the hospital after discussion with the Registrar.

5.12 Care of the Mother

Thromboprophylaxis
An individual risk assessment should be performed for each mother. Stillbirth is an independent risk factor for venous thromboembolism, which is thought to increase the risk as much as 6-fold[27,28]. Prophylactic low molecular weight heparin should be prescribed where indicated. If DIC is present then discuss thromboprophylaxis with a haematologist.

Suppression of lactation
This should be discussed and cabergoline 1 milligram **may** be administered orally, unless there is maternal hypertension/pre-eclampsia or puerperal psychosis. For rarer contraindications see the ICP page 21.

Human milk donation
This may be an option for mothers who choose to continue to express milk following the loss of their baby. While this option does not suit everyone, some families find comfort in continuing to express and donate. Healthcare professionals should discuss the option of milk donation with bereaved families in a culturally appropriate way to help make a decision that feels right for them. See the North West Human Milk Bank https://www.milkbankatchester.org.uk/donate/donationafterloss. A free, 2-hour Future Learn course is available to NHS staff. Lactation and Loss; Choices for Bereaved parents https://learninghub.nhs.uk/Resource/51570/Item.

Parents should be informed that there is a strict screening process for human milk donation. Sometimes the bank may be unable to accept milk if the mother has taken certain medication. Some medication may be safe when breastfeeding however may not be acceptable for donation purposes. Parents should also be informed that the milk bank is unable to accept milk if anyone in their household smokes. If a bereaved mother expresses a wish to donate, contact the milk bank who will talk the family through the donor recruitment process and answer any questions. Alternatively, parents can fill in the online screening form using the above link.

Contraception
This should be discussed before discharge home. FSRH Clinical Guideline Contraception After Pregnancy, available online: https://www.fsrh.org/Public/Standards-and-Guidance/Contraception-After-Pregnancy.aspx[29].

Communication
If the woman booked at another Trust, please inform their bereavement midwife of the pregnancy loss.

All outstanding maternity appointments should be cancelled to avoid potential upset. The mother should be offered a home visit by the community midwife.

5.13 Further Management of Baby Including Transfer and Funeral Arrangements

Transfer of baby to the mortuary

Ensure that the baby has been properly identified. Recommendations for this include applying two completed name bands e.g. “Baby of (mother’s name), mother’s identity number, date and time of birth as well as the hospital name”. Some Trusts use body labels as well, if this is the case, the card should read ‘baby of (Mother’s Name) and not as if it is the mother who has died. If the parents have given their baby personal items (teddy etc.) they should remain with the baby (unless the parents change their mind). These can be labelled using identification bands.

Prior to transfer to the mortuary some Trusts wrap the baby in a sheet or place in infant body bag, ensuring that all body parts including the face are covered. Attach second cot card or insert into the transport window of the infant body bag (if used).

Arrange transfer and if parents wish to accompany their baby, notify the anatomical pathology technician (APT) first. A member of maternity staff must accompany the family. The family may wish for the funeral director to collect the baby from the maternity unit rather than the mortuary. Please discuss this with the individual funeral director.

Taking baby home

Occasionally the family may wish to take their baby home or to a place which has a special significance for them. This is not always ideal as the baby may deteriorate rapidly and parents should be informed of this, especially if they wish to have a post mortem. The parents’ wishes should be supported. There is no legal reason why they cannot take their baby home or directly to the funeral directors of choice. The baby must be taken home in an appropriate casket or Moses basket. The transport home must be appropriate i.e. private not public transport. The mortuary must be informed if the parents are taking their baby home and a mortuary release form is required.

Some hospices offer the use of a cold room facility (see **Appendix 7**). 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. For further reading see Support for Clinicians – North West Neonatal Operational Delivery Network and https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/02/Hospice-Information.pdf

Funeral arrangements

Parents are legally responsible for ensuring that the body is lawfully buried or cremated if the baby died after 24 weeks’ gestation. If the parents would like the hospital to help them with the funeral arrangements, **refer to local hospital policy** and document the parents’ choices.

If the family choose a cremation, they should complete Cremation Form 3 (CF3) (application for cremation of re-mains of a stillborn child) and send it with a copy of the Stillbirth Certificate (known also as Cremation Form 9) to the dedicated individual in your trust who issues Cremation Form 10 (authorisation to cremate a stillborn child). If the family are arranging their own funeral the certificate for burial or cremation should be sent with the family who should be advised to give it to their funeral director.

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. However, if they do not, or if the Trust policy is to scatter ashes in a designated place e.g. 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.

After discharge

After the parents have returned home, they can arrange to return to hospital to see their baby. Advise the parents how to make these arrangements should they wish.

When such a request is received:

1. Obtain the parents' contact number.
2. Check whether the baby is still on hospital premises. This is particularly important if the baby was transferred out for post mortem.
   Viewings are arranged on an individual basis only at the referring hospitals.
3. Inform parents of the name of the person who will meet and accompany them.
4. Check that the baby is lying peacefully in the Moses basket; (with/wearing any clothing or items that have been specified by the parents).

Ongoing psychological support

All women and their partners should be offered bereavement support; this could be from a bereavement support midwife or counsellor who can provide bereavement support from diagnosis of the stillbirth until well into the postnatal period. They may be able to offer continuity and psychological support in subsequent pregnancies. Information about support groups should be offered. If the woman has ongoing psychological or a known psychiatric disease, the GP and health visitor should be made aware of this.

If the parents have given the baby a name, health care professionals should use the baby's name in all discussions with the family thereafter. Discuss with the mother when and where the postnatal debrief should take place; the appropriate appointment with the consultant obstetrician should be made. If the parents do not wish to return to see the consultant obstetrician, a letter should be sent to the family and the mother's GP.

5.14 Reporting: MBBRACE, PMRT, MNSI

MBRRACE-UK is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths. Each maternity unit will have a designated person responsible for reporting relevant deaths to MBRRACE-UK, for example the bereavement midwife or pregnancy loss co-ordinator. MBRRACE-UK notifications should be completed within 7 working days.

Eligible stillbirths to be reported include:

- All births from 22+0 showing no signs of life
- Babies born with no signs of life who weigh 400g or more, where an accurate estimate of gestation is not available

Intrapartum stillbirths must also be referred to the Maternity and Newborn Safety Investigations Programme (MNSI) for an external safety investigation.

Perinatal Mortality Review Tool (PMRT)

The PMRT is designed to support the **review** of the following perinatal deaths:

- Late fetal losses where the baby is born between 22+*0* and 23+*6* weeks of pregnancy showing no signs of life
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life
- All neonatal deaths where the baby is born alive from 22+*0* but dies up to 28 days after birth
- Post-neonatal deaths where the baby is born alive from 22+*0* but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die
- Gestation unknown, where the baby's weight is over 500g

All stillbirths should have a formal multidisciplinary review using PMRT to ascertain the cause of death (Relevant Condition at Death ReCoDe classification) **Appendix 6**.

Parents should be informed of the perinatal review process, given a letter of explanation and be invited to be part of the process. Parental questions should be invited and if there are none initially, parents should be asked a second time. Both dates should be recorded in the maternal records. Inform parents that they can submit questions up to 28 days following their stillbirth (see PMRT Parent Engagement Flow Chart). Parents will be supported throughout the process by the bereavement midwives. Trust governance and Duty of Candour processes should be followed.

For more information: https://www.npeu.ox.ac.uk/pmrt and https://www.sands.org.uk/our-work/fewer-baby-deaths/learning-lessons/national-perinatal-mortality-review

5.15 Follow Up Visit

Follow up of parents who experience a stillbirth is a key element of care, with an opportunity to assess wellbeing, both physical and psychological, as well as to convey information about investigations performed. Having one stillbirth increases the chance of recurrence 2 to 10-fold so it is also a chance to put in place a bespoke management plan for future pregnancies if the parents may be considering this in the future. Risk factors can be reviewed and addressed including the common risk factors for stillbirth such as maternal obesity, advanced maternal age, hypertension and smoking as well as others that are apparent from the maternal history or investigations.

Preparation is essential for any such consultation, for patients who have been through the experience of having a stillborn baby should not have the trauma of an unprepared consultation added onto that experience. It should be noted what the wishes are of the parents for follow up appointments. Some parents may find it too distressing to go back to the place where their baby died. If this is the case, arrangements should be made for follow up appointments to take place in another suitable setting or outside normal clinic hours. Bereaved parents should not have to sit with other mothers with healthy babies or attend an appointment in an antenatal or postnatal clinic. Parents should be encouraged to write down any questions they have and bring them to the appointment.

Prior to consultation ensure that:

1. All results are available.
2. Notes of any case review are available.
3. The PMRT report is available to be shared with the parents.

At postnatal follow up the clinician should ask about the psychological well-being of both parents and offer additional help if required. Particular care should be taken with women with a history of psychiatric disorder and other vulnerable groups of women. A high standard of communication is required between involved health professionals.

At the consultation possible areas for discussion include the following; however, this needs to be done sensitively to the woman's needs:

- Consider whether further investigations are required:
    - **Full thrombophilia screen** if placental histopathology shows maternal vascular malperfusion (MVM) / villitis of unknown (a)etiology (VUE) / fetal vascular malperfusion (FVM)
    - **Anti-cardiolipin and anti-phospholipid antibody screen** if placental histopathology shows chronic histiocytic intervillositis or massive perivillous fibrin deposition.

      ***** See clinical placental pathology decision tool (Appendix 8) for further information on further investigations to offer at follow up and how to modify care in the next pregnancy.[24]

  - **Maternal anti-Ro/La (SSA/SSB) antibodies** if hydrops fetalis and post mortem shows endomyocardial fibroelastosis/AV node calcification
  - **Maternal alloimmune anti-platelet antibodies** (blood samples are required from mother and father) if fetal intracranial haemorrhage is demonstrated on post mortem examination

- Results of investigations for stillbirth
- Likely cause of stillbirth
- Share PMRT report
- Pre-pregnancy plan for next pregnancy:
  - Smoking/alcohol status
  - Folic acid advice (400micrograms or 5mg)
  - Medication review
  - Optimisation of other medical conditions
- Pregnancy plan for next pregnancy:
  - Refer to Rainbow Clinic, Fetal Medicine Unit and/or Preterm Birth Clinic depending on the individual circumstances
  - Who to contact when pregnant
  - Consider aspirin 150mg per day until 36 weeks
  - Psychological support
  - Screen for gestational diabetes
  - Ultrasound scan schedule
  - Place of birth - choice of birth settings dependent upon risk factors
  - Timing of birth
  - Mode of birth discussion
  - Consider extra precautions for postnatal depression

Write a letter to the parents as well as communicating with the mother's General Practitioner. Ask the partner if they would like their GP to be informed about the stillbirth so it can be added to their notes, and record their response.

Feedback

Maternity units may wish to collect feedback from parents.

The feedback from women and families gathered from the questionnaire may identify aspects of care in maternity bereavement services which are excellent as well as areas for improvement which may help influence future care.

Below is an example of one that can be used:

Example letter to parent
Maternity Bereavement Experience Measure (MBEM)

5.16 Support Organisations and Groups

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).
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
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/

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

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/

Elli's Gift
Baby loss support and information.
Website: https://www.ellies.gift/
Email: support@ellies.gift

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

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/

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

Once Upon A Smile
Children's bereavement support
Phone: 0161 711 0339
Website: www.onceuponasmile.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

6 Monitoring and Audit

This guideline and the associated integrated care pathway have been peer reviewed by the Regional Guidelines Group. The documents will be updated via a similar peer review process after three years. Each maternity provider should agree a process for auditing local compliance with the guideline.

7 Appendices

Appendix 1 - Patient Information

Patient information

- https://www.sands.org.uk/sands-bereavement-support-book
- https://www.sands.org.uk/sites/default/files/Sands%20Bereavement%20Support%20Book%20-%20web%20version.pdf
- https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-when-your-baby-dies-before-birth.pdf
- https://twinstrust.org/bereavement/supporting-you/navigating-grief-booklet.html

Appendix 2 - The Butterfly Project

- https://www.neonatalbutterflyproject.org/

Appendix 3 – Hospital Post Mortem Examination Consent Form

Patient information

- https://www.sands.org.uk/support-you/understanding-why-your-baby-died/post-mortem-examination

Greater Manchester

- MFT Post mortem consent form
- MFT Post mortem help sheet for consent form
- Requesting a post mortem examination

Lancashire, South Cumbria, Cheshire and Merseyside

Patient information

https://www.liverpoolwomens.nhs.uk/media/3505/post-mortem-examination-hst-information-leaflet.pdf

- Alder Hey Post mortem consent form
- Alder Hey Examination of fetus request form

Appendix 4 – Placental Pathology

Greater Manchester

- MFT Placental histology information sheet
- Request Form for Histopathological Examination of Placenta

Lancashire, South Cumbria, Cheshire and Merseyside

- Saint Helens and Knowsley Cytology request form
- Alder Hey Request Form for Histopathological Examination of the Placenta

Placental swabs

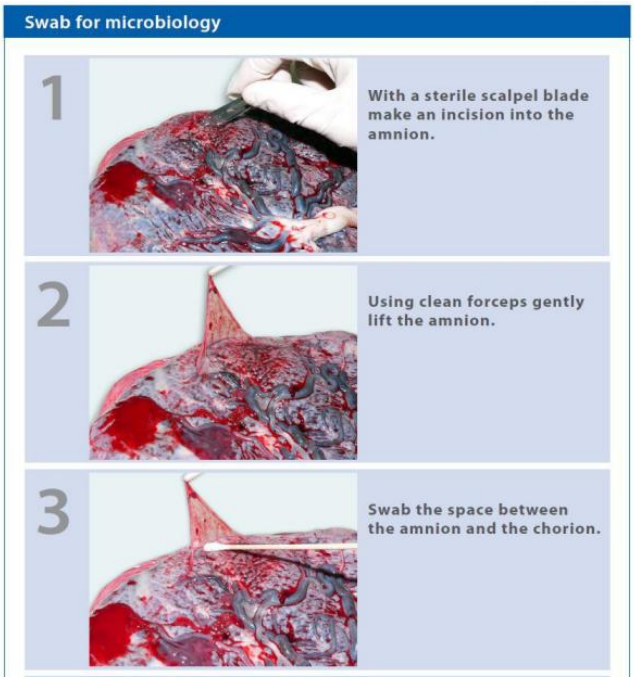

Image courtesy of South Australian Perinatal Practice Guideline: Histopathology Management of the Placenta
https://www.sahealth.sa.gov.au/wps/wcm/connect/a53e7080440106ec9ec6be1013b2c54b/Histopathology+Management+of+the+Placenta_PPG_v2_0.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-a53e7080440106ec9ec6be1013b2c54b-p4bHPBA

Appendix 5 - Cytogenetic Testing

Greater Manchester

Current forms can be printed from www.ManGen.org.uk/useful-forms

Cytogenetics referral form

Lancashire, South Cumbria, Cheshire and Merseyside

Current forms can be printed from Genetic Laboratory Services - Liverpool Women's NHS Foundation Trust or genetics-referral-form-feb-2020.pdf (liverpoolwomens.nhs.uk)

Cytogenetics request form

Appendix 6 – 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)

Appendix 7 – Palliative Care Hospice Information

Support for Clinicians – North West Neonatal Operational Delivery Network

Appendix 8 – Clinical Placental Pathology Tool

Placental_Pathology_Tool_Version_1.0 April

Clinical Placental Pathology Tool

8 Details of Other Relevant or Associated Documents

North West Management of Termination for Fetal Anomaly Guideline, version 1, April 2025.

9 Supporting References & National Guidance

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10 Definitions and Glossary

Stillbirth:
The definition of stillbirth 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)[3]:

"*a child which has issued forth from its mother after the 24th week of pregnancy and which did not at any time breathe or show any other signs of life*".

Late intrauterine fetal death (IUFD):
Late intrauterine fetal death refers to babies with no signs of life in utero after 24+0 completed weeks of pregnancy[3]

11 Consultation with Stakeholders

The guideline and integrated care pathway were circulated once for change requests then again for comments on the draft version. Circulation included bereavement midwives, consultant obstetricians and perinatal histopathologists working in the North West Regional Maternity Network, Heads of Midwifery, Clinical Directors, Maternity and Neonatal Voices Partnership representatives and the North West Regional Guidelines Group.

12 Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the group to identify where a policy or service may have a negative impact on an individual or particular group of people.

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Management of Stillbirth, Version 5
Directorate and service area:	Maternity Services
Is this a new or existing Policy?	Existing, updated from version 4, 2021
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Dr Elaine Church, Consultant Obstetrician
Contact details:	Elaine.church@mft.nhs.uk

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Staff caring for families who experience an intrauterine fetal death and/or stillbirth.
2. Policy Objectives	This guideline is written to support an integrated care pathway to facilitate optimal care following a stillbirth.
3. Policy Intended Outcomes	To facilitate optimal, family centred and compassionate care following an intrauterine fetal death and/or stillbirth.
4. How will you measure each outcome?	
5. Who is intended to benefit from the policy?	Staff caring for and families who experience an intrauterine fetal death and/or stillbirth.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: *Yes* • Patients/ visitors: *No* • Local groups/ system partners: *Yes* • External organisations: *Yes* • Other: *No*

6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Midwives, obstetricians, perinatal histopathologists, bereavement teams across the North West Maternity Network.
6c. What was the outcome of the consultation?	All comments received were considered and incorporated to improve the quality of the documents and to produce version 1.
6d. Have you used any of the following to assist your assessment?	National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys: No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	*No*	
Sex (male or female)	*No*	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	*No*	
Race	*No*	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	*No*	
Religion or belief	*No*	
Marriage and civil partnership	*No*	
Pregnancy and maternity	*No*	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	*No*	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

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

Name of person confirming result of initial impact assessment:

Dr Elaine Church, Consultant Obstetrician