North West Management of Stillbirth

Integrated Care Pathway Version 5

To be used in association with the North West Management of Stillbirth Guideline Version 5.

Use from 24+0 weeks gestation.

Less than 24+0 see Second Trimester Pregnancy Loss Guideline & ICP.
See Termination for Fetal Anomaly Guideline for TOPFA (all gestations).

Version 5
April 2025

Woman's Name: .....

Hospital Number: .....

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

Intrauterine fetal death ≥ 24+0 weeks gestation

Integrated Care Pathway (ICP)

Woman	Baby*	Baby
Last name:	Last name:	Last name:
First name:	First name: (if applicable)	First name: (if applicable)
Date of birth:	Date of birth:	Date of birth:
Hospital number:	Gender:	Gender:
Maternal BMI:	Weight:	Weight:
Ethnicity:	Ethnicity:	Ethnicity:
Parity:	Diagnosis:	Diagnosis:
Obstetric History:	Gestation:	Gestation:

Woman's contact details:	Partner's name: Partner's contact details:
Religion:	Partner's ethnicity:
Language:	Lead Consultant:
Interpreter required: Yes / No	Lead Midwife:
G.P: G.P address:	Additional information:

	* If one baby in a multiple pregnancy has died ask parents if they wish to use the Butterfly logo to identify this. (**See NW Management of Stillbirth Guideline V5, page 8 and appendix 2).**	Accepted ☐ Declined ☐ N/A ☐

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

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

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

Support colleagues

Principles

Ensure privacy

Involve both parents where appropriate

Use empathetic but unambiguous language

Respect religious/cultural beliefs and hold culturally appropriate discussions

Provide written information

Allow time for informed decision making

Use active listening

Promote continuity of care and carer

Involve experienced staff

Inform relevant care providers

Co-ordinate referrals

Complete documentation

Management

Page

Accountability

Signature	Print	Designation/Grade

Diagnosis and Immediate Care

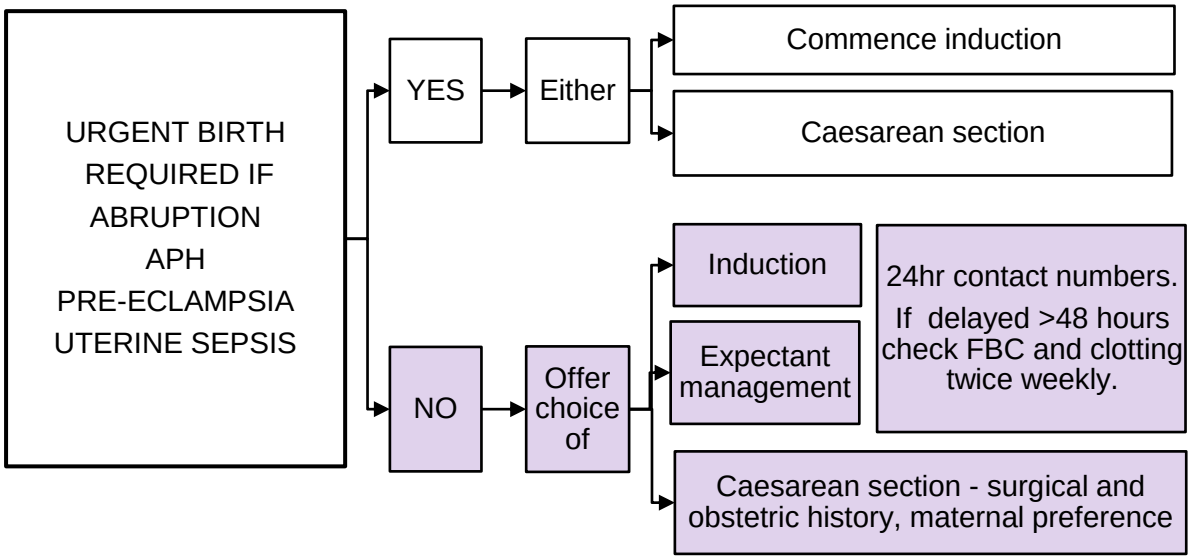
Intrauterine fetal death (IUFD) confirmed by ultrasound	Yes / No	
1st practitioner's name:	Date of scan:	Time of scan:
2nd practitioner's name:	Date of scan:	Time of scan:

Support	Offered	Accepted	Declined	N/A
Offer to contact partner, relative or friend who can attend to support				
Offer refreshments to the family				
Inform and offer support from the bereavement midwife				
Offer to contact the family's chosen religious leader or hospital pastoral care chaplaincy services if no specific faith				
Offer patient information leaflets: RCOG "When your baby dies before birth" or Sands "When a baby dies before labour begins"				
Inform the mother of the possibility of feeling passive fetal movements				

Bloods at Diagnosis	**Yes**	**No**	**Results**
FBC			
PT & APTT (& fibrinogen if applicable)			
U+E (if applicable)			
LFT (if applicable)			
Kleihauer in **ALL** women even if RhD positive			
If RhD negative and fetus RhD positive or unknown give Anti-D (may need further anti-D after birth)			
Group and save			

Observations			
Blood pressure		Respiratory rate	
Temperature		Conscious level	
Pulse		Uterine activity	
O^2 saturation		Urinalysis	
MEOWS Score		Action:	

Timing of Birth



Use BRAIN decision support tool:

B what are the benefits?
R what are the risks?
A what are the alternatives?
I what is my intuition / gut feeling?
N what happens if I do nothing?

Agreed management plan:

Women with one previous caesarean section:

In labour women should be monitored carefully with palpation of contraction length, strength and frequency, regular maternal observations and assessment of maternal behaviour. Clinical features that may suggest scar dehiscence/rupture include: maternal tachycardia, atypical pain, vaginal bleeding, haematuria and maternal collapse. A partogram should be completed to identify trends or concerns and facilitate timely escalation (see pregnancy loss partogram pages 8 & 9).

Women with two or more previous lower segment caesarean sections:

If the woman presents in labour and wishes a vaginal birth this should be supported if there are no contraindications, with careful monitoring as above. 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 the woman opts for induction of labour the protocol for women with a scarred uterus below is advised (pages 5-6). Maternal choice for caesarean section or vaginal birth should be supported.

Women with a classical or other atypical uterine scar (J, inverted T, myomectomy with breach of the uterine cavity), or previous uterine rupture:

Caesarean section is recommended.

Intrauterine Fetal Death in Women with an Unscarred Uterus

- If in labour or the maternal cervix is favourable, consider induction by amniotomy followed by oxytocin

- If the maternal cervix is unfavourable, use the mifepristone and misoprostol induction regimes indicated below, prescribed as per Trust medication prescription method

- 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

- **A single dose of mifepristone 200mg should be given prior to misoprostol**

- The woman then chooses her preferred interval of 0-24hrs (short protocol) or 24-48hrs (standard protocol) before misoprostol is administered

- Misoprostol is typically available as a 200 microgram scored tablet

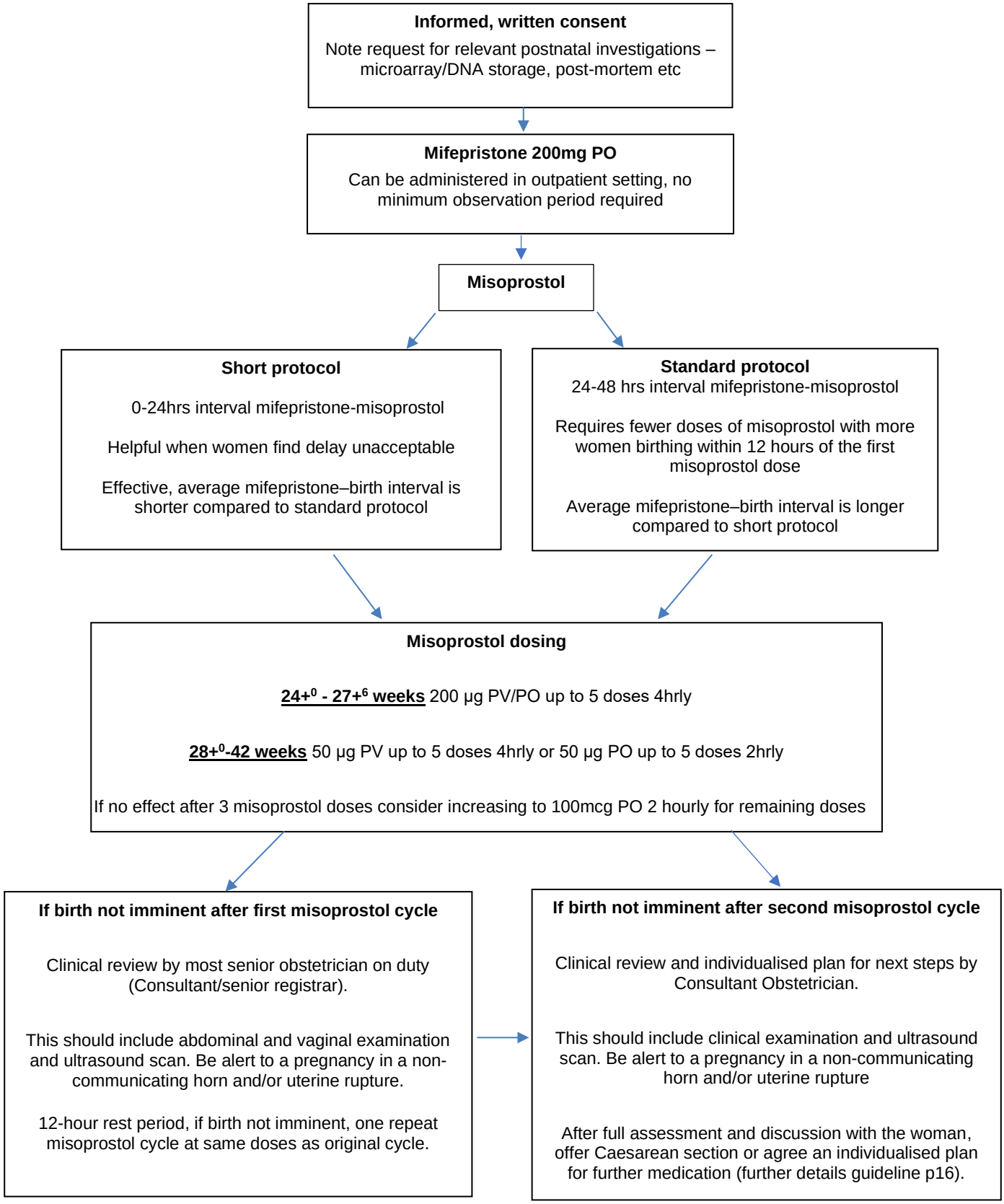
- 100 microgram doses can be obtained by dividing a 200 microgram tablet into two halves using a pill cutter. Similarly, 50 micrograms can be obtained by dividing the ½ tablet into 2 (i.e. ¼ tablet). It is recommended that the pill cutter is used for accurate division.

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 of vomiting and diarrhoea.
0-48 hrs later **28+0 to 42 weeks**	Misoprostol	50 micrograms PV 4 hourly or 50 micrograms PO 2 hourly (5 doses)	PV dose recommended (see above). If no response after 3 doses, consider increasing to 100mcg PO 2 hourly for the remaining doses.

- If birth has not occurred after a course of 5 doses of misoprostol, the mother should have a bedside review by the senior registrar or Consultant on call. This should include a physical examination and an ultrasound to rule out a uterine rupture or a pregnancy in a non-communicating horn.
- There is limited evidence on further management. If no concerns are identified, offer a repeat course of 5 doses of misoprostol at the same dose, starting 12 hours after the last dose.

- If birth has not occurred after a second course of 5 doses of misoprostol, the mother should have a bedside review by the Consultant on call. This should include a physical examination and an ultrasound to rule out a uterine rupture or a pregnancy in a non-communicating horn.
- Offer caesarean section, or if the woman wishes to avoid surgery, agree an individual plan for a further course of misoprostol / alternative medical therapy (see guideline p16 for details).

Unscarred Uterus

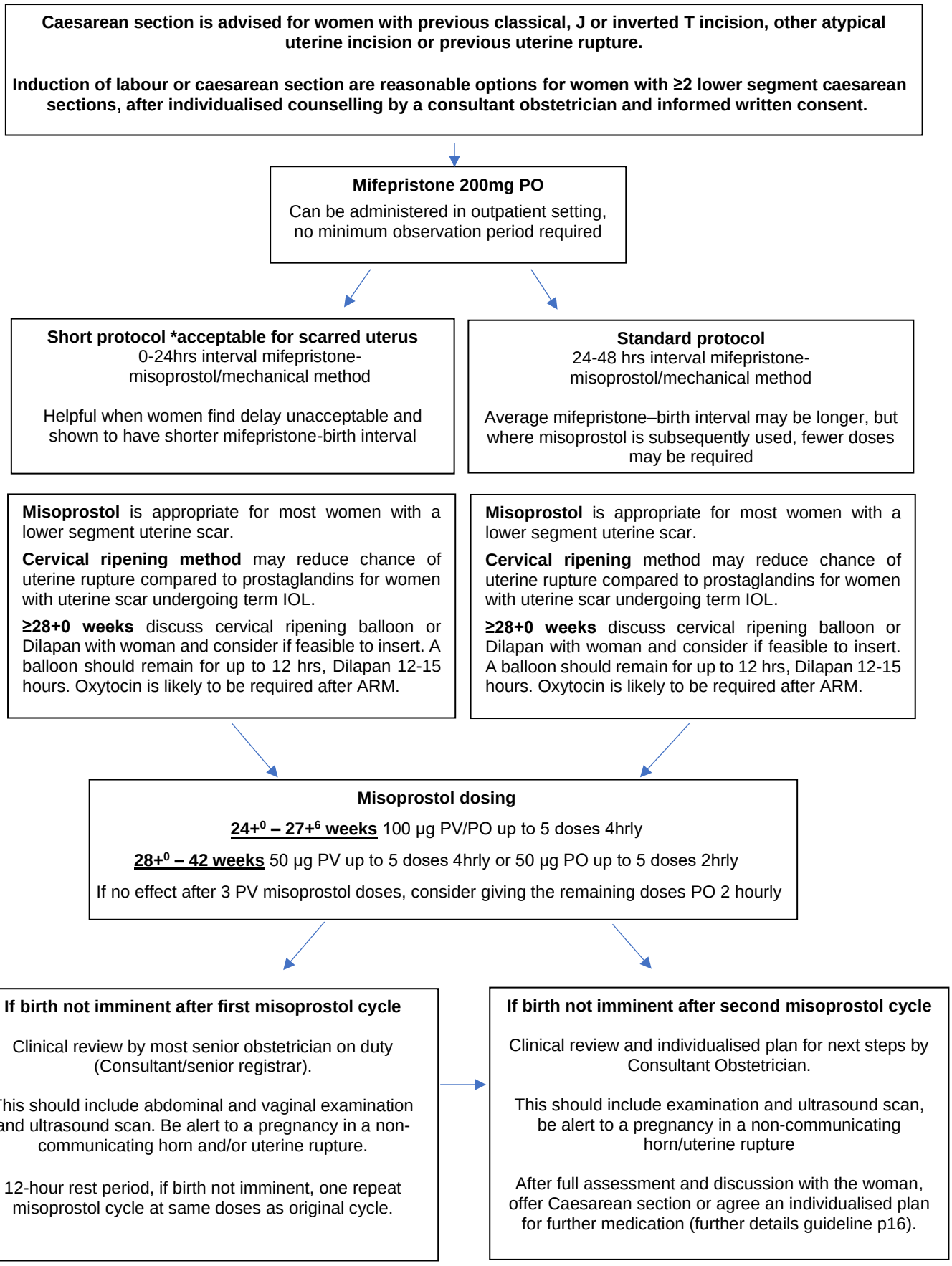


Intrauterine Fetal Death in Women with a Scarred Uterus: One previous lower segment caesarean section

- A single dose of mifepristone 200mg should be given prior to misoprostol
- The woman then chooses her preferred interval of 0-24hrs (short protocol) or 24-48hrs (standard protocol) before misoprostol is administered
- 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.
- 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 guideline development group recommend the doses in the table below.
- **If 28 weeks or more**, a cervical ripening balloon or other mechanical method such as Dilapan can be offered as an alternative to misoprostol. However, ARM and oxytocin are likely to be required after the mechanical method 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.

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)
24-48 hrs 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 or other mechanical method e.g. Dilapan **OR** Misoprostol	 50 micrograms PV 4 hourly or PO 2 hourly (5 doses)	CRB in for 12 hours Dilapan in 12-15 hours then assess for ARM If no response after 3 doses PV 4 hourly, consider giving the remaining doses PO 2 hourly.

Scarred Uterus



Care around Diagnosis

Location of care	Yes	No	N/A	Comments	Date	Signature
Orientate mother to her surroundings (e.g. bereavement suite, delivery suite) and explain call bell system						
Book admission for induction / section Avoid arrival with other parents having induction of labour / elective section						
Provide emergency telephone numbers						
Inform the bereavement midwife and provide the parents with their contact details						
If appropriate discuss possible postnatal investigations						
Inform the Consultant on call and the woman's named consultant				Detail who		
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.						
Cancel future antenatal, ultrasound and/or any additional appointments at other units/ departments/children centres						
Inform other services if applicable e.g. fetal medicine unit, diabetes, cardiology, mental health, teenage pregnancy, safeguarding				Detail who		
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.						
Complete an incident form						

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 Observations	Hours / Time	0	1	2	3	4	5	6	7	8	9	10	11	12
Pulse rate (x)														
180														
170														
160														
150														
140														
BP 4 hourly	130													
unless clinically	120													
indicated more	110													
frequently	100													
90														
80														
70														
60														
50														
40														
Respiratory rate														
Oxygen saturations														
Maternal temperature ^{0}C														
TOTAL MEOWS 4 hourly														
Drugs given/oral/IV fluids														
Urine output														
Urine dipstick														
Pressure areas checked														
Signature (initial)														

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

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

Care in Labour

	Signed	Date / Time
Inform consultant obstetrician		
Review the mother's birth plan		
Discuss analgesia options		
FBC / clotting / G&S		
Use bereavement specific partogram on previous page		

Labour and birth summary		
Mode of birth:	Perineum:	Estimated blood loss:
Placental weight g	Birth weight g	Birth weight centile

Umbilical Cord				
Fetal chromosome analysis	I consent that a sample of umbilical cord is taken for extracting DNA in order for chromosomal analysis to be performed. I understand that the sample may be stored for future diagnostic tests. Parent signature:…… Date:……	Sample needed 3cm section of umbilical cord placed in saline	Sample destination: Cytogenetics Test: Microarray If high chance aneuploidy screening will run PCR only	Offered Yes ☐ No ☐ N/A ☐ Accepted Yes ☐ No ☐ If cause for stillbirth is known then investigations may be omitted.
Number of vessels: 2 ☐ or 3 ☐ Knots in cord: Yes ☐ No ☐		Cord insertion position: (e.g. central, velamentous etc.)……. ……		
Looped round neck? Yes ☐ No ☐ If yes number of times…… Tight around neck? Yes ☐ No ☐ Loose? Yes ☐ No ☐		Other comments:		

Placenta	
Do not place in formalin (or other preservative as per local policy) until cord sample for chromosomal analysis (if indicated) and swabs for microbiology obtained (if required)	
Placental swabs clean an area of the fetal surface away from the cord insertion with an alcohol wipe, incise with a scalpel, lift the amnion with forceps and swab between the amnion and chorion	**Microbiology** Offered: Yes ☐ No ☐ N/A ☐ Accepted: Yes ☐ No ☐ N/A ☐
Manual removal of placenta Yes ☐ No ☐ If yes, was it morbidly adherent? Yes ☐ No ☐ Request form for placental pathology (Appendix 4 in Management of Stillbirth Guideline V5) **Placental Pathology** Offered: Yes ☐ No ☐ If Yes; Accepted ☐ (i.e. gave verbal consent) or Declined ☐	

Care of the Baby

	Yes	No	N/A	Comments	Date	Signature
Identify baby - attach 2 name bands with Baby of (mother's name), mother's hospital number, date and time of birth						
Birth weight and centile						
Ask if the mother wishes to see her baby immediately	1st offer			Ask parents twice if initially decline		
	2nd offer					
Discuss the care of the baby with the parents						
Offer naming and / or blessing or other by family's chosen religious or other leader				Write the name of the baby on page i and 27 and refer to the baby with the chosen name		
Discuss and offer to take memento photographs. Give the parents the opportunity to take their own photographs. If photographs taken by Medical Illustration, obtain verbal or written consent as per Trust policy.	1st offer			Ask parents twice if initially decline		
	2nd offer					
Verbal consent for external examination of baby				Findings should be recorded on page 13		
Offer the parents the opportunity to hold their baby and spend time together						
Offer the use of the cooling cot (if available) to maintain baby's skin condition						
If the parents consent other family members may hold the baby.						

	Yes	No	N/A	Comments	Date	Signature
Provide the parents with the opportunity to choose clothes and blankets for the baby and give them the option to choose a teddy or other item to remain with the baby						
Ask parents if they would like to dress the baby themselves Dress baby and carefully and respectfully lay the baby in as natural position as possible in a Moses basket/cold cot Use appropriately sized clothes				Some parents may wish to wash their baby. If for religious or personal reasons, parents do not wish their baby to be washed, wishes should be respected.		
Offer parents the opportunity to make an entry into the Remembrance Book						
Offer to help the parents to start a memory box						
Discuss personal items: • Hand and foot prints (if feasible) • Lock of hair • Name band • Cord clamp • Cot card • Tape measure	1st offer 2nd offer			Ask parents twice if initially decline		

Clinical Examination of the Baby

Verbal consent obtained and documented (page 11) for external examination of baby

MEASUREMENTS
Weight _____g Length _____cm
Head circumference _____cm

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

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

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

NAILS
☐ All present
If not, describe _____
_____

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

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

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

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

SEX
☐ Male ☐ Female
☐ Ambiguous

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

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

EARS

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

If other, describe _____

_____

NECK

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

If other, describe_____

CHEST

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

If other, describe _____

_____

ABDOMEN

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

BACK

☐ Normal ☐ Spina bifida

If spina bifida, level of defect:

☐ Scoliosis ☐ Kyphosis
☐ Other

If other, describe_____

_____

LIMBS

Length

☐ Normal ☐ Long
☐ Short - which segments seem short_____

Form

☐ Normal ☐ Asymmetric
☐ Missing Parts

If abnormal describe _____

_____

Position

☐ Normal ☐ Clubfoot
☐ Other

If abnormal describe_____

_____

HEAD AND FACE

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

If abnormal describe _____

EYES

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

If other describe _____

NOSE

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

If other describe_____

MOUTH

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

If cleft, give location: _____

☐ Left ☐ Right
☐ Bilateral ☐ Midline

Mandible

☐ Normal size ☐ Large
☐ Small ☐ Other

Any other abnormality_____

_____

_____

Examination performed by

Name: _____

Designation: _____

Signature: _____

Date: _____

Investigations

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

Further investigations required? Yes ☐ No ☐

If no state reason _____

OFFER TO ALL*	***Unless cause known and lead clinician customises further investigations**					
	Other information	**What**	**Destination**	**Date**	**Yes**	**No**
Kleihauer	For all women, even if Rhesus positive to identify large feto-maternal haemorrhage	Maternal blood sample. Specify stillbirth ? feto-maternal haemorrhage	Blood transfusion lab			
Maternal viral serology	Toxoplasma Rubella Cytomegalovirus Herpes Parvovirus B19 (especially if hydrops) Syphilis serology (if not screened at booking)	Maternal blood sample	Virology			
Fetal infection screen	Swab from baby's axilla Placental swabs (see page 10 for details)	Bacterial swabs	Microbiology			
Post mortem	Prior to consent parents should be given written patient information about a post mortem. Leaflet offered ☐ Yes ☐ No ☐ Accepted ☐ Declined Consent should be by an appropriately trained individual. Full or limited post mortem may be performed. Consent obtained ☐ Yes ☐ No ☐ Accepted ☐ Declined	Complete and send: PM consent form (Appendix 3 Stillbirth Guideline) Perinatal hospital post mortem referral form (contains mother's details, history, reason for PM request). Report all infectious agents to the pathologist (e.g. coronavirus, hepatitis, HIV).	Paediatric histopathology, Saint Mary's Hospital for GM. Alder Hey Hospital for Cheshire and Mersey.			
Placental pathology	Should be offered even if post mortem is declined	Placental swabs and cord samples should be taken prior to placing the placenta in formalin.	Placental pathology request forms and swab instructions in Appendix 4, Stillbirth Guideline			

The following selective investigations should only be offered if clinically indicated:

If clinically suspected maternal infection						
	Other information	**What**	**Destination**	**Date**	**Yes**	**No**
Maternal infection screen	FBC CRP Lactate Blood cultures MSU HVS Endocervical swab (chlamydia) Respiratory virus swabs (flu, covid)	Maternal blood Culture Urine Swabs	Haematology Biochemistry Microbiology Virology			
If no obvious cause						
Thyroid function, diabetes, cholestasis	Thyroid function HbA1c Random glucose Bile acids	Maternal blood	Biochemistry			
Fetal chromosome testing						
Do not offer if known fetal anomalies and prenatal genetic testing (amnio or CVS) has been carried out and result known	Fetal chromosome testing	Take 3cm of umbilical cord and place in saline for transport. Written consent should be obtained from the mother - section 6 of the post mortem consent form if having PM (Appendix 3, Stillbirth Guideline).	North West Genomic Laboratory Hub			
If history suggestive of maternal substance use						
Urine for cocaine metabolites	Maternal consent required	Urine for cocaine metabolites	Chemical pathology			
If hydrops fetalis						
	Anti Ro (SSA) and La (SSB) antibodies Red cell antibody screen Clinical genetic examination Skeletal survey	Maternal blood Genetic examination X-rays	Immunology			

Perinatal Death Certification

General points

- The Medical Certificate of Stillbirth is a legal document and must be accurate. Accurate determination of the cause of stillbirth is important for understanding the causes of, and preventing, stillbirth.
- The ReCoDe classification should be used to guide the classification of stillbirth and to write the certificate.
- An MDT rapid case review within 72 hours in all cases of stillbirth with senior obstetric involvement (Consultant or senior registrar) can aid in identifying the cause. It is essential that the predisposing factors, pregnancy chronology, presentation and postnatal events are reviewed again with investigation results at the PMRT review.
- See the "4Ps of perinatal death certification" as a structure for considering which items should be reviewed.

The medical examiner does not need to be informed of stillbirths.

Inform the Coroner if birth unattended or doubt as to whether the baby was born alive.

Inform the police if there is suspicion of a deliberate action.

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

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

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

Stillbirth notification completed	Date:
Stillbirth certificate completed	Date:
Signature:	Name:
Designation:	Registration Number (PIN/GMC):

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

Registration

- Parents must be informed that legally their baby's stillbirth must be registered within 42 days (on rare occasions by next of kin).
- Please note: If the mother is remaining an inpatient but husband (married only) is registering the stillbirth at the Registrar's Office give him the stillbirth certificate and instructions on what to do.
- If the parents are unmarried but wish to have the father's surname entered, the couple must present together.
- If same sex couple notify the Registrar prior to the appointment.
- Give the stillbirth certificate to parents if required (see local policy as stillbirth certificate may be required to be emailed to the registry office or Trust bereavement office)

Registered in hospital before discharge	Yes ☐ No ☐ N/A ☐
Home with instructions on how to register the baby	Yes ☐ No ☐ N/A ☐

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

Before writing the certificate, please note the following:

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

ReCoDe Classification of Stillbirth

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

Perinatal Death Certification – the 4 Ps

Predisposing factors

Risk factors

Any identifiable maternal risk factors?

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

Pregnancy Course

Evidence of FGR or placental insufficiency?

- Review customised centile chart and calculate IBC

FGR implicated by:

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

If FGR present consider (A)

Is there abnormal liquor volume (without SROM history)?

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

Was termination of pregnancy conducted?

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

Multiple pregnancy?

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

Presentation

At labour/birth

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

Postnatal events

Placental examination:

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

Neonatal examination:

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

Maternal symptoms

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

Postnatal Care of Mother

	Yes	No	N/A	Comments	Date	Signature
Discuss suppression of lactation If accepted give cabergoline 1mg PO If declined or contraindicated discuss alternative methods				Cabergoline contraindicated if allergy to ergot alkaloids, history of puerperal psychosis, pulmonary/pericardial/ retroperitoneal fibrosis and cardiac valvulopathy. Caution with hypertension and pre-eclampsia.		
Discuss the option of breast milk donation in a culturally appropriate way				North West Human Milk Bank		
Check FBC, review and action result during admission						
If RhD negative and fetal RhD status is positive or unknown discuss with transfusion whether a further dose of anti D is required				Note that a further dose may be required after birth even when given at time of diagnosis		
Obtain the woman's consent to attach a tear drop sticker / other bereavement logo to the paper or electronic notes				Verbal consent acceptable		
Complete the bounty suppression form or activate local agreement						
Ensure the woman has a Consultant review during her admission						
Discuss postnatal recovery and expectations						
Complete thrombo-prophylaxis risk assessment and prescribe low molecular weight heparin if required						
Discuss contraceptive options						
Discharge the mother as per Trust policy						
Ensure she has any required take home medication e.g. analgesia, iron, LMWH						
If booked at another Trust, inform their Bereavement Midwife of the stillbirth						

Postnatal Care of Mother

	Yes	No	N/A	Comments	Date	Signature
Does the woman consent to a community midwife visit?						
If a visit is declined: notify the community midwife of the stillbirth to avoid inappropriate contact						
Does the woman consent to a health visitor visit?						
Inform GP by sending discharge summary to the surgery, highlighting the stillbirth outcome. If community midwife visit is declined, advise the woman to see her own GP.						
Inform health visitor						
Ensure that the parents have all the relevant contact details if there are complications following discharge. Options are: -Bereavement midwife -Community midwife -Maternity triage -Consultant's secretary						
Offer advice regarding expected emotional reactions and difficulties Provide information leaflets and details of support groups and contact numbers – give page 30/31 in the back of ICP				Document leaflets given		
Inform the parents that they are able to come back to spend time with their baby if they wish. Advise that they should phone to arrange this in advance.				Advise where viewing would take place. Inform parents sensitively that natural changes may occur. This is influenced by the condition of the baby at birth and the degree of maceration present.		

Reporting: MBRRACE, PMRT, MNSI

	Yes	No	N/A	Comments	Date	Signature
Bereavement midwife or nominated individual should complete MBRRACE Perinatal Death Surveillance notification for all births from 22+0 showing no signs of life including babies weighing 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						
Explain the Perinatal Mortality Review Tool (PMRT) review process to the parents and record parents' questions in the box below						
Give the PMRT leaflet to the parents (local or national)						
Inform the PMRT lead to ensure the review is scheduled						
Inform parents of the annual Service of Remembrance						
Arrange a postnatal debrief appointment				It may take between 8 and 12 weeks for all investigations results to be received. In the meantime, remind the woman to make contact with her G.P. regarding her wellbeing		

Parent questions for Perinatal Mortality Review Tool review:

Please note parents have 28 days to submit questions. If there are no immediate questions, the bereavement midwife should ask again on a second occasion within 28 days.

Date asked: …… **2nd date asked: …….**

Transfer of Baby to the Hospital Mortuary

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

Taking a Stillborn Baby Home

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

Funeral Arrangements

	Yes	No	N/A	Comments	Date	Signature
Parents are legally responsible for ensuring burial / cremation of their baby from 24+0 weeks Discuss local options available						
Provide local leaflets / Sands booklet						
If the parents would like the hospital to help them with the funeral arrangements, refer the parents to the bereavement team as per local hospital arrangements.						
Once the stillbirth has been registered the Registrar will issue a certificate for burial or cremation (stillbirth)						
If the family are choosing to have hospital burial or cremation the certificate for burial or cremation (stillbirth) should be given to the dedicated individuals as highlighted in your trust policy, i.e. mortuary or bereavement centre						
If the family are arranging their own funeral the certificate for burial or cremation (stillbirth) should be sent with the family and advise them to give to their funeral director						
If the parents choose to have a hospital cremation or a private cremation the form/notification must be sent to the mortuary with the baby				If hospital cremation ask parents what they wish to do with the ashes. If they wish to collect them advise when and where this will occur. If ashes to be retained follow local guidance		

Debrief Visit Prompt List

Date: _____ Support person (partner, friend, other) _____

Date of stillbirth: _____ Baby's name: _____

Counselling offered Yes ☐ No ☐ Already receiving ☐

Investigation Results	Performed		Result
	Yes	No	
Post mortem			
Placental pathology			
Fetal chromosome analysis			
Fetal axillary swab			
Placental swabs			
Kleihauer			
Virology results: Toxoplasma Rubella Cytomegalovirus Herpes Parvovirus B19 Syphilis serology			
Other investigations: TFT HbA1C Random glucose Bile acids			
Review Perinatal Mortality Review Tool (PMRT) report and share with family			

Likely Cause of Stillbirth

Any further investigations required				Yes	No
If placental pathology shows	Maternal vascular malperfusion (MVM), fetal vascular malperfusion (FVM) or villitis of unknown etiology (VUE)	Maternal blood	Full thrombophilia screen See clinical placental pathology decision tool in guideline p34		
If placental pathology shows	Chronic histiocytic intervillositis (CHI) or massive perivillous fibrin deposition (MPFD)		Antiphospholipid and anticardiolipin antibody screen		

If post mortem shows hydrops / endomyocardial fibroelastosis / AV node calcification	Anti-Ro/La (SSA/SSB) antibodies	Maternal blood	Immunology		
If fetal intracranial haemorrhage (at post mortem)	Maternal alloimmune antiplatelet antibodies	Blood sample from mother and father	Immunology		
Parental chromosomes	Only if 1 Unbalanced fetal karyotype found 2 Fetal chromosome analysis fails and there is: a) Fetal abnormality on USS or PM b) Previous unexplained stillbirth c) Recurrent miscarriages		North West Genomic Laboratory Hub		
Other investigations					

Plan for Future Pregnancy

Smoking status / advice	
Alcohol use	
Weight / BMI	
Medication review	
Who to contact when pregnant	
Consider referral to Rainbow Clinic, Fetal Medicine Unit or Preterm Birth Clinic	
Antenatal plan of care - consider: Aspirin 150mg at night Glucose tolerance test Uterine artery Doppler Serial growth scans	
Timing of birth	
Place of birth	
Mode of birth	

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

Notes

NHS North West

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

NHS North West

Parking Permit

Authorised by (PRINT NAME) _____ Authoriser's signature_____

Authorisers contact phone number_____ Date of issue _____

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

Start date _____

End date _____

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

Greater Manchester Strategic Clinical Network
4th Floor | 3 Piccadilly Place | Manchester | M1 3BN
http://www.gmecscn.nhs.uk/

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