

# North West

## Second Trimester Miscarriage

(formerly Second Trimester Pregnancy Loss)

# Integrated Care Pathway

## Version 4 April 2026



**To be used from 13+0 weeks to 23+6 weeks gestation with the North West Management of Second Trimester Miscarriage Guideline, version 4, April 2026.**

**From 24+0 weeks please see North West Stillbirth Guideline and ICP, version 5, April 2025.**

**For termination of pregnancy please use North West Management of Termination for Fetal Anomaly Guideline, version 1, April 2025.**

**For a baby born with signs of life at any gestation who dies, please use the North West Neonatal Death Guideline and ICP, version 1, April 2025.**

**Guideline produced on behalf of the North West Regional Maternity Team**

NW Second Trimester Miscarriage ICP V4 April 2026		Issue Date	April 2026	Version	V4
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Principles	Communication	Management	Page
<ul style="list-style-type: none"> <li>• Ensure privacy</li> <li>• Involve both parents where appropriate</li> <li>• Use empathetic but unambiguous language</li> <li>• Care with compassion</li> <li>• Respect religious and cultural beliefs</li> <li>• Provide culturally appropriate care</li> <li>• Provide written information</li> <li>• Offer choice</li> <li>• Allow time for decision making</li> <li>• Use active listening</li> <li>• Repeat information</li> <li>• Promote continuity of care and carer</li> <li>• Involve experienced staff</li> <li>• Inform relevant care providers (e.g. GP)</li> <li>• Coordinate referrals</li> <li>• Complete notifications</li> <li>• Complete documentation</li> </ul>	<ul style="list-style-type: none"> <li>• With parents</li> <li>• Answer questions openly and honestly</li> <li>• If you do not know the answer, say so and find someone who can answer the question</li> <li>• With colleagues</li> <li>• Support colleagues</li> </ul>	<ul style="list-style-type: none"> <li>Diagnosis and Immediate Care</li> <li>Timing of Birth</li> <li>Communication Following Diagnosis</li> <li>Induction Regime</li> <li>Bereavement Partogram</li> <li>Care During Labour and Birth</li> <li>Care of Baby</li> <li>Clinical Examination of Baby <math>\geq 16+0</math></li> <li>Investigation of Miscarriage</li> <li>Miscarriage Certification</li> <li>MBRRACE Reporting</li> <li>PMRT</li> <li>Postnatal Care of Mother</li> <li>Taking a Baby Home</li> <li>Funeral Arrangements</li> <li>Transfer of Baby to the Mortuary</li> <li>Follow Up Visit Prompt List</li> <li>Notes Pages</li> <li>Support Organisations and Groups</li> <li>Parking Permit</li> </ul>	<ul style="list-style-type: none"> <li>4</li> <li>5</li> <li>6</li> <li>7</li> <li>8</li> <li>10</li> <li>12</li> <li>14</li> <li>16</li> <li>18</li> <li>18</li> <li>18</li> <li>20</li> <li>22</li> <li>23</li> <li>23</li> <li>24</li> <li>27</li> <li>29</li> <li>38</li> </ul>

## Accountability

Name	Signature	Role

## Second Trimester Miscarriage (13+0-23+6 weeks)

Woman	Baby	Baby
Surname:	Surname:	Surname:
First name:	First name: (if applicable)	First name: (if applicable)
Date of birth:	Date of birth:	Date of birth:
Hospital number:	Gender if known:	Gender if known:
Maternal BMI:	Weight:	Weight:
Ethnicity:	Diagnosis:	Diagnosis:
Deprivation index 1-10:	Gestation:	Gestation:

Woman's telephone number:	Partner's name and telephone number:
Consultant:	Partner's ethnicity
Language:	Faith / beliefs:
Interpreter required:      Yes/No	Named / allocated midwife:
G.P.:	Additional information/special circumstances:

Additional information	
Gravidity:                      Parity:	Previous miscarriages:
Past obstetric history:	
Past medical / surgical history:	
Medication:	
<b>Allergies:</b>	
Working diagnosis:	Date and Time:

**The purpose of this ICP is to encourage high-quality, compassionate care, however women and families have individual needs and wishes, therefore variances from this pathway may occur in order to provide truly personalised care and choice to women.**

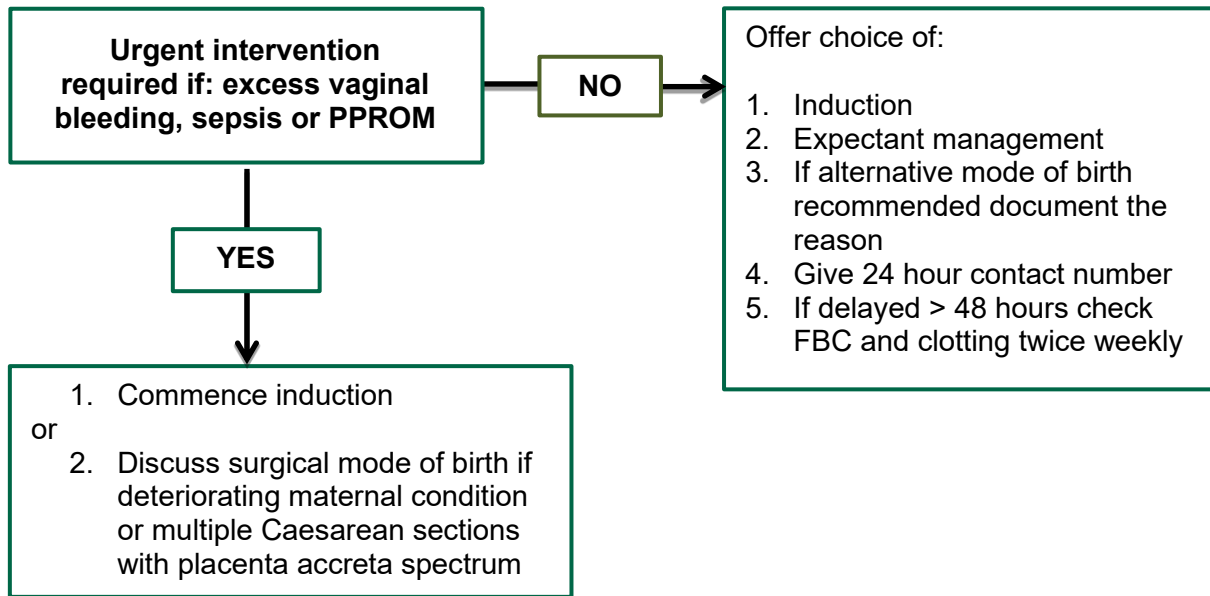
## Diagnosis and Immediate Care

Fetal death in utero confirmed by ultrasound	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no, reason:
1st practitioner's name:	Role:		Date and time:
2nd practitioner's name:	Role:		Date and time:

Immediate 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 / nurse				
Offer to contact the family's chosen religious leader or hospital pastoral care chaplaincy services if no specific faith				
Offer patient information leaflets: Miscarriage Association "Late Miscarriage: Second Trimester Loss" up to 15+6 weeks RCOG "When your baby dies before birth" from 16+0 weeks				

Immediate Care:				
Blood pressure		O2 saturation		
Temperature		Conscious level		
Pulse		Urinalysis		
Respiratory rate		MEWS		
Clinical examination if bleeding / in labour:		Yes	No	Results
Abdomen				
Speculum (vaginal examination only if in labour)				
Investigations at diagnosis:		Yes	No	Results
FBC / group & save				
PT & APTT +/- fibrinogen if concerned re DIC				
Kleihauer in all RhD negative women and If clinical suspicion eg bleeding in RhD positive women				
If Rh negative give Anti-D if fetus Rh positive or unknown - Kleihauer will guide further anti D dosing				
TORCH screen in DCDA co-twin demise if sFGR				
Infection screen indicated?		Yes	No	Results
HVS and endocervical swabs				
Throat / nasal swabs				
MSSU				
Lactate / CRP / blood cultures				
Are antibiotics indicated? (broad spectrum)				

# Timing of Birth



## 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:

Induction	Surgical (discuss impact on investigations)
Expectant	N/A

**What matters to me:** (explore cultural, spiritual, emotional and practical preferences)

## Communication Following Diagnosis

Location of care	Yes	No	N/A	Comments	Date	Signature
Book medical management/induction date & time, ensure a suitable room for bereaved parents avoiding arrival with other parents						
Provide emergency telephone numbers to call if concerns prior to admission						
Discuss possibility of feeling passive fetal movements if the mother had been feeling fetal movements before diagnosis						
Inform: <ul style="list-style-type: none"> <li>• Consultant</li> <li>• Consultant's secretary</li> <li>• Bereavement midwife</li> <li>• Health visitor</li> </ul>				Who contacted		
Cancel antenatal, ultrasound / any additional appointments at other hospitals/ children centres and inform parents this has been done so they do not need to do this						
Inform other departments if applicable: Eg. Fetal medicine unit / diabetic team / cardiology / teenage pregnancy / safeguarding team / mental health team				Who contacted		
Provide the parents with a compassionate car parking pass if required - detach back page of booklet (also has details of support groups for parents).  If electronic / barrier parking liaise with security / car parking office to waive parking charges / lift barrier on exit						
Offer spiritual / faith / pastoral support						
If appropriate discuss giving birth, postnatal investigation and management						
Offer emotional support and be sensitive. Parents will be distressed and frightened. Answer questions honestly. If you do not know the answer, say so, and find someone to assist you.						
Complete an incident form if $\geq 22$ weeks						



\* If one baby in a multiple pregnancy has died ask parents if they wish to use the Butterfly logo (see **NW Management of Second Trimester Pregnancy Loss Guideline V4, section 5.5)**

Accepted   
 Declined   
 N/A

# Induction Regime

Fetal Death In Utero 13+0 – 23+6 weeks					
<b>Pre-Induction</b>	Mifepristone 200 milligrams orally once only				
Normal interval between mifepristone and misoprostol is 24 hours to 48 hours though this can be shortened if clinically needed.					
	<table border="1"> <thead> <tr> <th>Unscarred uterus</th> <th>Scarred uterus</th> </tr> </thead> <tbody> <tr> <td>Misoprostol 400 micrograms, 3 hourly, for 5 doses pv</td> <td>Misoprostol 200 micrograms 3 hourly, for 5 doses pv</td> </tr> </tbody> </table>	Unscarred uterus	Scarred uterus	Misoprostol 400 micrograms, 3 hourly, for 5 doses pv	Misoprostol 200 micrograms 3 hourly, for 5 doses pv
Unscarred uterus	Scarred uterus				
Misoprostol 400 micrograms, 3 hourly, for 5 doses pv	Misoprostol 200 micrograms 3 hourly, for 5 doses pv				
<b>Induction</b>					
<p>Vaginal route preferable due to lower incidence of side effects. Avoid vaginal route if excess bleeding. Misoprostol can also be given sublingual (under the tongue) or buccal (in the cheek).</p>					
<p>If birth not achieved after the doses above, senior obstetric review, USS (consider implantation in a non-communicating horn or uterine rupture), discuss with the Consultant, offer a second course of misoprostol after a 12 hour interval.</p>					
<p>If birth not achieved after a second course of misoprostol, repeat clinical assessment and discuss with the woman the use of Carboprost before resorting to surgical management. IM Carboprost 250mcg (doses given 3hrs apart, up to max. 8).</p>					
<p>Mifepristone contraindicated if uncontrolled severe asthma, chronic adrenal failure, acute porphyria. Misoprostol used in caution with conditions that are exacerbated by hypotension (cerebrovascular or cardiovascular disease) and inflammatory bowel disease.</p>					

Medication Given	Dose	Route	Date	Time
Mifepristone				
Misoprostol				

# Second Trimester Miscarriage Partogram

Name	Gestation				Para															
	Labour induced/spontaneous (please circle)	Time of onset of labour	Time of spontaneous membrane rupture/ARM	Birth preferences	Time of onset of labour	Time of spontaneous membrane rupture/ARM	Time of onset of labour	Time of spontaneous membrane rupture/ARM												
Birth partner	Birth preferences				Blood group															
Significant medical or obstetric history																				
Liquor = Clear/Mec/BS/Nil																				
Contractions per 10 minutes	5																			
Weak (W)	4																			
Mod (M)	3																			
Strong (S)	2																			
Strong (S)	1																			
5ths Palpable																				
Cervix (cm)	10																			
plot ●	9																			
Descent of head/pp	8																			
plot X	7																			
-2	6																			
-1	5																			
0	4																			
+1	3																			
+2	2																			
+2	1																			
Fetal position	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Syntocinon (Y/N)																				
mls per hour																				

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

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

Signature (initial)

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

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

## Care During Labour and Birth in Maternity

	Signed	Date / Time
Ensure the woman has her chosen birth partner /support person with her		
Orientate mother to her surroundings (bereavement suite/delivery suite) and explain the call bell system		
Inform consultant obstetrician of admission		
Discuss analgesia options including entonox, diamorphine IM, fentanyl PCA, epidural		
Discuss maternal birth preferences		
Use the bereavement specific partogram p8-9		
Advise the use of a bedpan on the toilet		
Syntometrine or oxytocin IM should be offered for third stage as per local policy		
If there is a delay in delivery of the placenta by $\geq 30$ minutes after the fetus, an additional dose of misoprostol can be given		
If the placenta is retained for more than an hour, counsel the woman for surgical removal (required in 1:5) due to bleeding risk		
If surgical removal of placenta required, brief the theatre staff of the situation of miscarriage and inform them that the placenta needs to be kept for swabs and histology		

### Labour and birth summary

Mode of birth:	Perineum:	Estimated blood loss:
Placental weight                      g	Birthweight                              g	Centile:
<b>Baby born with signs of life:    Yes <input type="checkbox"/>    No <input type="checkbox"/></b>		
<p><b>If yes, move to Neonatal Death ICP, April 2025. Do not continue with this ICP.</b>  Call a doctor to see the baby immediately. If the baby dies due to extreme prematurity they must have been seen by a doctor whilst alive in order for a death certificate to be completed.</p>		

### Additional Information

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

Umbilical Cord				
Number of vessels: 2 <input type="checkbox"/> or 3 <input type="checkbox"/> Knot in cord: Yes <input type="checkbox"/> No <input type="checkbox"/>		Cord insertion position: (e.g. central, velamentous etc.) _____ _____		
Looped round neck? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes number of times _____ Tight around neck? Yes <input type="checkbox"/> No <input type="checkbox"/> Loose? Yes <input type="checkbox"/> No <input type="checkbox"/>		Other comments:		
Fetal chromosome analysis	<b>Only send sample of umbilical cord if fetal abnormality, or if requested by genomics or if recurrent miscarriage</b>	Sample needed:  3cm section of umbilical cord in saline PLUS maternal EDTA blood sample IF tissue is unidentifiable.	Sample destination: Genomics	Offered Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>  Accepted Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If cause of death is known then investigations may be omitted.</b>				

Placenta		
Do not place in formalin until cord sample for chromosomal analysis and swabs for microbiology have been obtained if required.		
Placental swabs:  Clean an area of the fetal surface away from the cord insertion with an alcohol wipe, lift the amnion with forceps and incise with a scalpel and swab between the amnion and chorion.	Microbiology	Offered: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>  Accepted: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Surgical evacuation of placental tissue	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, was it morbidly adherent? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Verbal consent for histopathological examination of the placenta obtained.  Preserve in formalin (or other preservative as per local policy) whilst awaiting transport to laboratory ONLY after taking swabs and segment of cord for fetal chromosomal analysis if required.  Placenta to be transported with baby if postmortem accepted	Placental pathology offered: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>  If yes: Accepted (verbal consent) <input type="checkbox"/> or Declined <input type="checkbox"/>  Postmortem accepted: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	

## Care of Baby

	Yes	No	N/A	Comments	Date	Signature
Do the parents wish to see/hold their baby immediately?  Each parent may have different preferences.						
Ask the parents how they wish to refer to their baby – for example baby, fetus, do they have a chosen name?						
Identify baby. Use 2 name bands.  Attach one name band to the baby. Second identity band next to baby.  Ensure 3 identifiers “Baby of [mother’s name/mother’s NHS number/date of baby’s birth, hospital].						
Whilst parents are spending time with their baby, offer the use of a cooling cot to maintain baby’s skin condition.						
With parents’ consent offer other family members the opportunity to hold the baby.						
Ask the parents if there are cultural or religious customs which are important to the family, in line with their faith, beliefs and worldview and ensure that these are supported wherever possible.						
Ask the parents if they would like their baby to be blessed and inform the hospital chaplain or appropriate religious leader if preferred.						
Ask the parents for consent to perform an initial examination if above 16+0 weeks.				Document on p14-15		
Weigh the baby and document weight.						
Calculate birth weight centile (if 22+0 weeks or more).						
Complete Non Viable Fetus Form (to authorise the sensitive disposal, burial or cremation of the fetus before 24 weeks gestation).						

Provide the parents with the opportunity to choose clothes and blankets for the baby.						
Discuss and offer to take memento photographs. Offer the parents the opportunity to take their own photographs. If taken by Medical Illustration documented parental consent required.						
Offer to start a memory box with the parents: <ul style="list-style-type: none"> <li>• Hand and foot prints</li> <li>• Foot casts</li> <li>• Name band</li> <li>• Cord clamp</li> </ul>						
Ask parents if they would like to dress the baby themselves. If gestation appropriate, use appropriately sized clothes.				If parents do not wish their baby to be dressed, use white sheets.		
Offer parents the opportunity to make an entry into the remembrance book.						
In the event of birth of a multiple pregnancy at the threshold of viability with one surviving baby consider the Butterfly Project (page 23 in the STPL Guideline) <a href="https://www.neonatalbutterflyproject.org/">https://www.neonatalbutterflyproject.org/</a>  Provide the parents with the Twins Trust leaflet <a href="https://twinstrust.org/bereavement">https://twinstrust.org/bereavement</a>						
Carefully and respectfully lay the baby in as natural position as possible in a Moses basket/crib/cuddle cot.						
Offer to arrange transfer to a local hospice if the family wish (see guideline appendix 7 for details of local hospices)						

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

Verbal consent obtained and documented for external examination of baby (page 17)

## MEASUREMENTS

Weight \_\_\_\_\_g

Birth Weight Centile \_\_\_\_\_

## MACERATION

*Fresh*: no skin peeling

*Slight*: focal minimal skin slippage

*Mild*: some skin sloughing, moderate skin slippage

*Moderate*: much skin sloughing but no secondary compressive changes or decomposition

*Marked*: advanced maceration

## HANDS

Normal appearance

Abnormal appearance

If abnormal describe \_\_\_\_\_

## FINGERS

Number present \_\_\_\_\_

If not 4+4 please describe \_\_\_\_\_

Abnormal webbing or syndactyly

If abnormal describe \_\_\_\_\_

## THUMBS

Number present \_\_\_\_\_

If not 1+1 please describe \_\_\_\_\_

Unusual position of fingers

Looks like a finger

If abnormal describe \_\_\_\_\_

## FEET

Normal appearance

Abnormal appearance

If abnormal describe \_\_\_\_\_

## TOES

Number present \_\_\_\_\_

If not 5+5 please describe \_\_\_\_\_

Abnormal spacing

If abnormal describe \_\_\_\_\_

## GENITALIA

Anus  Normal

Imperforate  Other

If other please describe \_\_\_\_\_

## SEX

Male  Female

Ambiguous

***The gender may not be clear at earlier gestations, if so, be honest with the parents and do not assign a gender.***

## EARS

Normal  Low set

Pre-auricular tags  Pre-auricular pits

Posteriorly rotated  If other describe \_\_\_\_\_

## NECK

Normal  Short

Excess  Cystic mass

/redundant skin (hygroma)

If other describe \_\_\_\_\_

## CHEST

Normal  Long/narrow

Short and broad  Other

Describe \_\_\_\_\_

## ABDOMEN

Normal  Flattened  Distended

Hernia  Omphalocele

Gastroschisis

# Clinical Examination of Baby

## BACK

Normal  Spina bifida   
 If spina bifida, level of defect \_\_\_\_\_  
 Scoliosis  Kyphosis  Other   
 If other describe \_\_\_\_\_  
 \_\_\_\_\_

## LIMBS

Length  
 Normal  Long  Short\*   
 \*If short, which segments seem short \_\_\_\_\_  
 \_\_\_\_\_

## Form

Normal  Asymmetric   
 Missing Parts   
 If abnormal describe \_\_\_\_\_  
 \_\_\_\_\_

## Position

Normal  Clubfoot   
 Other   
 If abnormal describe \_\_\_\_\_  
 \_\_\_\_\_

## HEAD AND FACE

Head relatively normal   
 Collapsed  Anencephalic   
 Hydrocephalic  Abnormal shape   
 If abnormal describe \_\_\_\_\_  
 \_\_\_\_\_

## EYES

Normal  Prominent   
 Sunken  Straight   
 Upslanting  Downslanting   
 Far apart  Close together   
 Eyelids fused  Other   
 If other describe \_\_\_\_\_  
 \_\_\_\_\_

## NOSE

Normal  Abnormally small   
 Asymmetric  Abnormally large   
 Nostrils  Apparently patent   
 If other describe \_\_\_\_\_  
 \_\_\_\_\_

## MOUTH

Normal size  Large  Small   
 Upper lip  Intact  Cleft\*   
 If cleft, give location: \_\_\_\_\_  
 Left  Right   
 Bilateral  Midline

## Mandible

Normal size  Large   
 Small  Other

Any other abnormality \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Examination performed by

Name \_\_\_\_\_  
 Designation: \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Date: \_\_\_\_\_

## Investigations After Birth

If cause of miscarriage is fetal aneuploidy or lethal congenital anomaly, further investigations may not be required. The woman's named consultant may also customise investigations.

Investigations to be offered? Yes  No  If no, reason: \_\_\_\_\_

**Offer to All** *\*if the parents are unsure give them time and contact numbers if they have questions / change their minds*

Offer to all	Other information	What	Destination	Date	Yes	No
<b>Kleihauer</b>	All Rh neg women / if clinical suspicion <b>irrespective of Rh status</b>	Maternal blood	Blood Transfusion			
<b>Fetal infection screening</b>		Swab from baby's axilla	Microbiology			
		Placental swab from between amnion and chorion – p10	Microbiology			
<b>Maternal serology</b>	Toxoplasma CMV Rubella Parvovirus B19 Syphilis if not screened at booking	Maternal blood	Virology			
<b>Placental pathology from 14/40</b>	Recommended even if post mortem examination is declined.  Take swabs and cord samples (if required) prior to placing placenta in formalin	Whole placenta and membranes	<16 weeks and no PM – local hospital in GM.  >16 weeks, no PM, paediatric histopathology, St Mary's Hospital Manchester.  Alder Hey Hospital for Cheshire & Mersey.			
<b>Postmortem</b>	Consent should be taken by a clinician with appropriate consent training	Clinical summary / maternity notes or post mortem information form				

**Thrombophilia screen is no longer indicated at this stage – await placental pathology result – offer at follow up visit if required - see page 25.**

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**Selective Investigations** (offer only if there is a clinical indication)

Selective investigations	Other information	What	Destination	Date	Yes	No
<b>If ≥16+0 weeks external examination of baby</b>	To identify any major fetal abnormalities	External examination				
<b>If clinically suspected maternal infection</b>	If maternal flu like illness, abnormal coloured liquor; prolonged ruptured membranes	Blood cultures lactate, CRP MSU, HVS endocervical swab, throat/nose swab	Microbiology			
<b>If mother symptomatic / clinical suspicion</b>	Herpetic lesions	Herpes swab / serology				
<b>If there is no obvious cause</b>	Maternal thyroid function HbA1c	At delivery	Chemical Pathology			
<b>If fetal anomaly (except for isolated neural tube defect which is unlikely to have a genetic cause) or chromosomal anomaly suspected, or if 3<sup>rd</sup> consecutive miscarriage</b>	Fetal chromosomes  Take 3cm of umbilical cord and place in saline ( <b>not formalin</b> ) for transport.  If no identifiable umbilical cord: send 2cm <sup>3</sup> of placenta	3cm of umbilical cord  <b>Do not send more than the required amount of tissue.</b>  If tissue unidentifiable, send maternal blood sample in EDTA tube as well.	Cytogenetics, St Mary's Hospital/ Liverpool Women's Hospital			
<b>If fetal anomalies suspected</b>	Discuss with local clinical genetics whether fetal genetic examination appropriate	Whole fetus transferred via mortuary	St Mary's Hospital 0161 276 6506 Liverpool Women's Hospital 0151 702 4229			
<b>If suspected maternal substance abuse</b>	Requires maternal consent	Urine for cocaine metabolites	Chemical Pathology			
<b>If hydrops fetalis</b>	Anti Ro (SSA) Anti La (SSB) antibodies RBC antibody screen Clinical genetic examination Skeletal survey		Immunology  Blood Transfusion			

## Miscarriage Certification

	Yes	No	Signature
Signpost parents to the link below via which they can request a baby loss certificate			
<a href="https://www.gov.uk/request-baby-loss-certificate">https://www.gov.uk/request-baby-loss-certificate</a>			

## Reporting to MBRRACE

Late fetal losses from 22+0 weeks should be reported to MBRRACE-UK via SPEN (Submit a Perinatal Event Notification) <https://notify-perinatal-events.nhs.uk/>.

**It is not necessary to report late fetal loss to the medical examiner or coroner if the baby was born without signs of life.**

	Yes	No	N/A	Comments	Date	Signature
Notify designated person responsible for reporting via SPEN.						
Report late fetal losses from 22+0 to 23+6 weeks showing <b>no</b> signs of life, irrespective of when the death occurred.						

## Perinatal Mortality Review Tool (PMRT)

Late fetal losses, where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g, qualify for a local multidisciplinary review of care using the **Perinatal Mortality Review Tool (PMRT)**.

	Yes	No	N/A	Comments	Date	Signature
Explain the PMRT process to the parents						
Give PMRT leaflet to parents (local or national)						
Inform PMRT lead to ensure review is scheduled						
Ask the parents if they would like to submit any questions to be considered at the PMRT review						

**Parent questions for Perinatal Mortality Review Tool review:**

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

First date parents asked:

Second date:

Questions:

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## Postnatal Care of Mother

	Yes	No	N/A	Comments	Date	Signature
Support from bereavement midwife/nurse						
Offer advice regarding expected emotional reactions and difficulties. Provide information about support groups (page 29)						
VTE score/risk assessment as per Trust guideline				LMWH to be prescribed if required		
Review need for other take home medication						
Check Rhesus status and check that anti D has been given if required				Check whether anti D was given at diagnosis and check Kleihauer result to guide whether further anti D is required		
If ≥18 weeks discuss expression and donation to the Milk Bank at Chester in a culturally sensitive way.  If declined, discuss suppression of lactation if ≥ 18 weeks.  If cabergoline declined or contraindicated discuss natural suppression.				Cabergoline 1mg PO. Contraindicated if allergy to ergot alkaloids, history of puerperal psychosis, pulmonary/ pericardial /retro-peritoneal fibrosis, cardiac valvulopathy. Caution hypertension and pre-eclampsia.		
Discuss the option to have breast milk jewellery made						
Attach a tear drop sticker / other bereavement logo to the hospital notes / electronic equivalent				Verbal consent acceptable		
Complete the Bounty suppression form or activate local agreement						
Ensure a senior / consultant obstetrician / gynaecologist review prior to discharge						
Inform parents of annual service of remembrance						
If the woman booked at another Trust inform their Bereavement Midwife of the pregnancy loss.						
Discuss and provide contraception of the woman's choice if possible						

## Postnatal Care of Mother

	Yes	No	N/A	Comments	Date	Signature
Ensure the parents have relevant contact details e.g. <ul style="list-style-type: none"> <li>Bereavement Midwife</li> <li>Community Midwife</li> <li>Maternity Triage</li> <li>Gynae Assessment Unit</li> <li>Early Pregnancy Unit</li> </ul>						
Inform the mother that she is able to come back to spend time with her baby if she wishes. Advise that she should phone the relevant department to arrange to visit in advance. Advise where she should attend.				Inform parents sensitively that natural changes may occur (influenced by the condition of the baby from birth and the degree of maceration)		
Inform GP and send the discharge summary to the surgery highlighting the fetal loss outcome.						
If $\geq 16/40$ does the woman consent to a community midwife visit? Follow local policy.						
Communication of outstanding screening results by the screening midwife (as per local policy)				See STPL guideline (Appendix 8)		
Arrange postnatal follow-up with Consultant Obstetrician/ Gynaecologist to discuss investigation results.				It may take 12 weeks for a full postmortem report to be received		

## Taking a Baby Home

	Yes	No	N/A	Comments	Date	Signed
Discuss the option of taking their baby home (if the baby has been referred to the medical examiner or coroner – release form required though this is rare in second trimester miscarriage).				If the baby is to have a postmortem examination inform the parents that taking their baby home may affect the postmortem examination results. Discuss the option of taking the baby home after the postmortem.		
Discuss the loan of a cuddle cot at home.						
The baby must be taken home in an appropriate casket or Moses basket.						
The means of transport home must be private not public.						
Complete local documentation follow local procedure.						
The parents then take responsibility for arranging the funeral or home burial.						

## Funeral Arrangements

Whilst there is no legal requirement to bury or cremate babies <24 weeks gestation, many families will wish to.

As per local arrangements and gestation	Yes	No	Comments	Date	Signature
Discuss the options available for burial/cremation of their baby. Document parents' wishes.					
If the parents request the hospital to help with funeral arrangements, follow local policy.					
If an individual cremation is chosen, ask the parents what they would like to do with the ashes.					
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.					

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## Transfer of Baby to the Hospital Mortuary

	Yes	No	N/A	Comments	Date	Signature
Inform parents where the baby will be taken once they go home.						
Check baby's identity labels contain 3 identifiers.						
Complete relevant labels / documentation for your unit and place with the baby.						
Toys and personal effects to be placed with the baby for transfer.						
The baby should remain dressed for transfer to the mortuary, unless otherwise directed by the parents.						
Prepare baby for transfer. Ideally a privacy pram should be used for the transfer.						
Ask parents if they wish to take the baby to the mortuary accompanied by a health professional or whether they wish a health professional to do so.						
If the parents are not accompanying baby to the mortuary the baby should be placed in a body bag by clinical staff after the parents have said their goodbyes.						
Ensure that all relevant information is sent to the pathologist if a postmortem is being performed as per local policy e.g. complete postmortem request form or send a clinical summary with the consent form.						
All appropriate funeral documentation should be completed as per local policy.						
Inform the mortuary prior to transfer.						

# Follow Up Visit Prompt List

**Prior to Consultation**

1. Ensure all results are available
2. Notes of local case review are available
3. PMRT report may be available depending on timing of review

Visit date: \_\_\_\_\_

Ensure woman has appropriate support (partner, friend, translator, other individual need)

Date of pregnancy loss \_\_\_\_\_ Baby's name \_\_\_\_\_ Gestation \_\_\_\_\_

Counselling offered Yes  No  Already receiving  Other \_\_\_\_\_

Investigations	Performed		Result
	Yes	No	
Kleihauer			
Fetal axillary swab			
Placental swab			
Postmortem			
Placental pathology			
Fetal chromosome analysis			
Toxoplasma			
Rubella			
CMV			
Parvovirus B19			
Syphilis			
TFT			
HbA1C			
Others			

<b>Cause (if known)</b>

Are Further Investigations Required?				Yes	No
<b>If placental pathology shows maternal vascular malperfusion (MVM), fetal vascular malperfusion (FVM) or villitis of unknown etiology (VUE)</b>	Full thrombophilia screen:  Lupus anticoagulant Anticardiolipin and anti-beta2-glycoprotein-1 (anti-B2GP1) antibodies Factor V Leiden Prothrombin gene mutation Protein S Protein C	Maternal blood	See clinical placental pathology decision tool in guideline p33/p40		
<b>If placental pathology shows chronic histiocytic intervillitis (CHI) or massive perivillous fibrin deposition (MPFD)</b>	Lupus anticoagulant Anticardiolipin and anti-beta2-glycoprotein-1 (anti-B2GP1) antibodies	Maternal blood			
<b>If recurrent miscarriage</b>	Full thrombophilia screen	Maternal blood			
<b>If post mortem shows hydrops /endomyocardial fibroelastosis / AV node calcification</b>	Anti-Ro/La (SSA/SSB) antibodies	Maternal blood	Immunology		
<b>If fetal intracranial haemorrhage (at post mortem)</b>	Maternal alloimmune antiplatelet antibodies	Blood sample from mother and father	Immunology		

## Follow Up Visit Prompt List

### General Points Discussed

Pre-pregnancy advice for next pregnancy:

- |                                                    |                                                     |
|----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Smoking cessation         | <input type="checkbox"/> Folic acid supplementation |
| <input type="checkbox"/> Safe alcohol consumption  | <input type="checkbox"/> BMI optimisation           |
| <input type="checkbox"/> Illicit drug use          | <input type="checkbox"/> Psychological wellbeing    |
| <input type="checkbox"/> Safe caffeine consumption | <input type="checkbox"/> Contraception              |

Advise parents that following a second trimester pregnancy loss:

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

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**Other medical issues, medications, pre pregnancy medical conditions****Plan for next pregnancy**

- Book under Consultant Obstetrician
- Consider whether referral to the recurrent miscarriage team is required
- Consider whether referral to Rainbow Clinic is required (see local criteria)
- Consider referral to preterm labour clinic for cervical length scans or cervical suture depending on presentation and likely cause of miscarriage. For future pregnancies, consider history-indicated insertion of cervical cerclage and if recurrent second trimester pregnancy loss consider transabdominal cerclage (TAC)
- Consider whether aspirin or LMWH are indicated
- Consider offering extra ultrasound scans for reassurance
- If chronic histiocytic intervillitis on placental histology discuss with Rainbow Clinic at St Mary's Hospital or Wythenshawe for commencement of aspirin, LMWH, prednisolone and hydroxychloroquine at 7 weeks gestation after an early viability scan, followed by close ultrasound surveillance.
- If second trimester miscarriage due to placental cause advise uterine artery Doppler at 20-23 weeks and offer growth scans from 32 weeks as per SBL3.2 moderate risk pathway for fetal growth restriction
- Personalised plan for birth
- Consider extra precautions for postnatal depression

**Following the consultation**

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

**Consultation performed by**

Name \_\_\_\_\_ Designation: \_\_\_\_\_

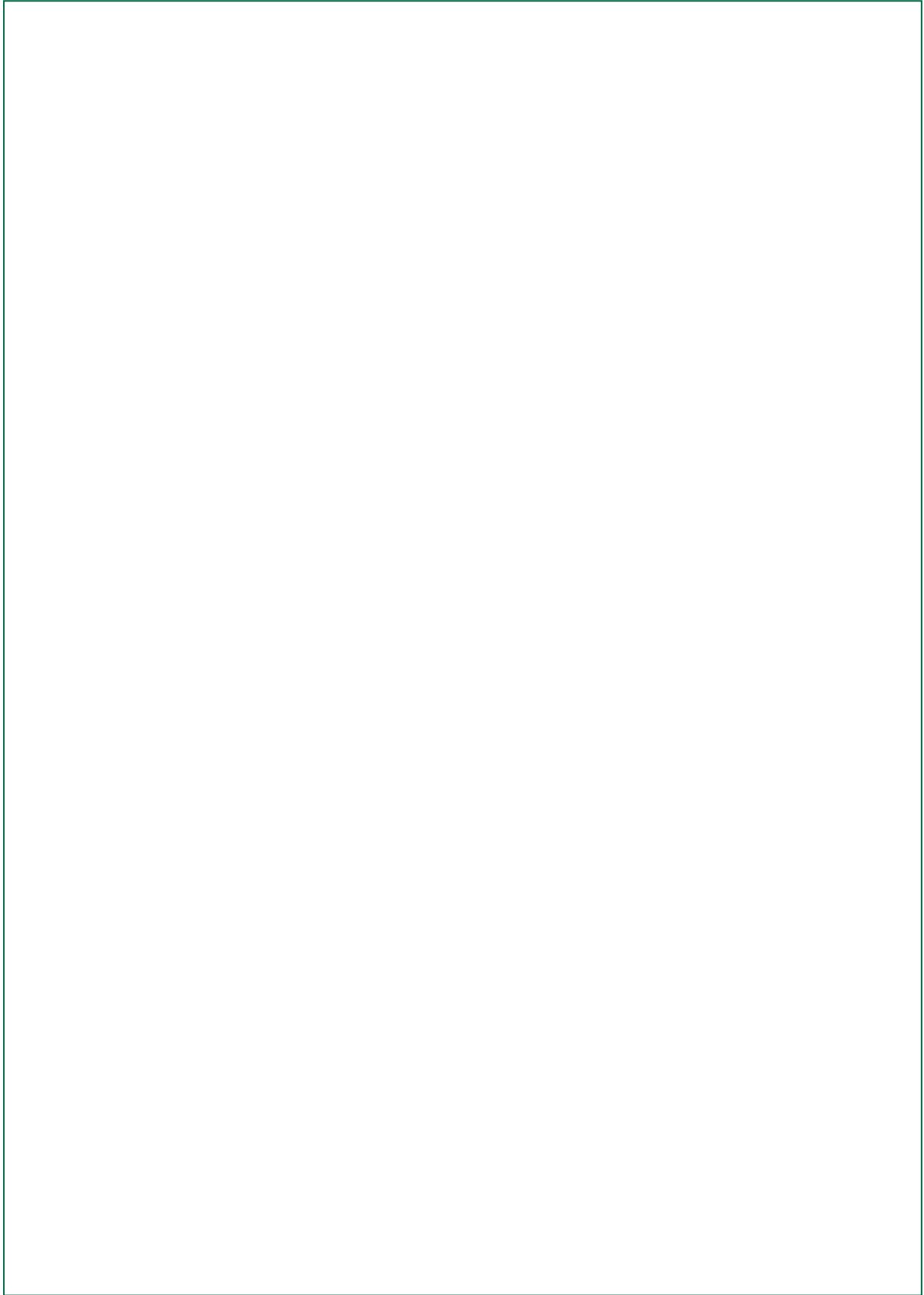
Signature \_\_\_\_\_ Date: \_\_\_\_\_

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# Notes

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# Support Organisations and Groups

## Alder Centre

Providing care and education for anyone affected by the death of a child, of any age.

**Website:** [www.alderhey.nhs.uk/the-alder-centre/](http://www.alderhey.nhs.uk/the-alder-centre/)

## Bliss

Family support helpline offering guidance and support for premature and sick babies.

**Website:** [www.bliss.org.uk/](http://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](http://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](mailto:info@childrenofjannah.com)

**Website:** [www.childrenofjannah.com](http://www.childrenofjannah.com)

## CRADLE

Providing a range of services to support anyone affected by early pregnancy loss

**Website:** [Home | Cradle Charity](http://Home|CradleCharity)

## 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/>

## Finding Rainbows

Child and baby loss support based in Ashton, Tameside

**Website:** <https://findingrainbows.org/>

## Jewish Bereavement Counselling Service

Supporting Jewish individuals through loss and bereavement

**Helpline:** 020 8951 3881

**Email:** [enquiries@jbcs.org.uk](mailto:enquiries@jbcs.org.uk)

**Website:** [www.jbcs.org.uk](http://www.jbcs.org.uk)

## Lullaby Trust

Bereavement support to anyone affected by the sudden and unexpected death of a baby.

**Helpline:** 0808 802 6868

**Website:** <http://www.lullabytrust.org.uk>

## Lighthouse Therapy Service

Post Infant Loss Support Service covering Merseyside

**Website:** [Support Group | Lighthouses Therapy Services](http://SupportGroup|LighthousesTherapyServices)

## Listening Ear

Free self-referral counselling to help deal with anxiety, bereavement and depression.

**Helpline:** 0151 488 6648

**Email:** [enquiries@listening-ear.co.uk](mailto:enquiries@listening-ear.co.uk)

**Website:** <http://listening-ear.co.uk/>

## Liverpool Bereavement Services

Provide 1:1 counselling for people who are struggling with a loss.

**Website:** <https://liverpoolbereavement.com/>

## Love Jasmine

Support for families directly affected by the loss of a child. Providing practical, emotional and respite support and promoting self-care to improve the emotional wellbeing of the whole family.

**Phone:** 0151 459 4779 (Mon-Fri 0930 – 1700)

**Or call/text:** 07566 225 253

**Website:** <https://www.lovejasmine.org.uk/>

## North West Forget me not's & Rainbows

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

**Facebook:** [nwforgetmenotsandrainbows](https://www.facebook.com/nwforgetmenotsandrainbows)

## Once Upon A Smile

Children's bereavement support

**Phone:** 0161 711 0339

**Website:** [www.oucesmile.org.uk](http://www.oucesmile.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](http://www.petalscharity.org)

## Sands Stillbirth & Neonatal Death Charity

Support for families affected by the death of a baby before, during or shortly after birth.

**Helpline:** 0808 164 332

**Website:** <http://www.uk-sands.org>

## SPACE

A Liverpool-based peer support network for those facing miscarriage or infertility

**Website:** [www.thereisspaceforyouhere.com](http://www.thereisspaceforyouhere.com)

## The Compassionate Friends UK

Offering support to bereaved parents and their families

**Helpline:** 0845 123 2304

**Email:** [info@tcf.org.uk](mailto:info@tcf.org.uk)

**Website:** [www.tcf.org.uk](http://www.tcf.org.uk)

## The Miscarriage Association

Support for parents who have experienced miscarriage

**Helpline:** 01924 200799 (9am to 4pm)

**Email:** [info@miscarriageassociation.org.uk](mailto:info@miscarriageassociation.org.uk)

**Website:** [www.miscarriageassociation.org.uk/](http://www.miscarriageassociation.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](http://tommys.org/stillbirth-information-and-support)

## Twins Trust

Bereavement and special needs support groups

**Email:** [enquiries@twinstrust.org](mailto:enquiries@twinstrust.org)

**Website:** [www.twinstrust.org/bereavement](http://www.twinstrust.org/bereavement)

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# Parking Permit

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

Authorised by (PRINT NAME) \_\_\_\_\_ Authoriser's signature \_\_\_\_\_

Authoriser's contact phone number \_\_\_\_\_ Date of issue \_\_\_\_\_

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

Start date \_\_\_\_\_

End date \_\_\_\_\_



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