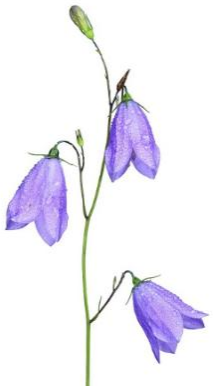
North West
Second Trimester Miscarriage
(formerly Second Trimester Pregnancy Loss)

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

Principles

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

Communication

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

Management

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:	
Allergies:	
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 ☐ No ☐	NA ☐ 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

Urgent intervention required if: excess vaginal bleeding, sepsis or PPROM

NO

Offer choice of:

1. Induction
2. Expectant management
3. If alternative mode of birth recommended document the reason
4. Give 24 hour contact number
5. If delayed > 48 hours check FBC and clotting twice weekly

YES

1. Commence induction

or

2. Discuss surgical mode of birth if deteriorating maternal condition or multiple Caesarean sections with placenta accreta spectrum

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: • Consultant • Consultant's secretary • Bereavement midwife • Health visitor				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 ≥ 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	
Pre-Induction	Mifepristone 200 milligrams orally	
Normal interval between mifepristone and misoprostol is 24 hours to 48 hours though this can be shortened if clinically needed.		
	Unscarred uterus	Scarred uterus
Induction	Misoprostol 400 micrograms, 3 hourly, for 5 doses pv	Misoprostol 200 micrograms 3 hourly, for 5 doses pv
Vaginal route preferable due to lower incidence of side effects. Avoid vaginal route if excess bleeding. Misoprostol can also be given sublingual (under the tongue) or buccal (in the cheek).		
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.		
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).		
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.		

Medication Given	Dose	Route	Date	Time
Mifepristone				
Misoprostol				

Second Trimester Miscarriage Partogram

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

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

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

Syntocinon (Y/N)																									
mls per hour																									

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

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

Signature (initial)																										

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

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

Care During Labour and Birth in 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 ≥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:

Baby born with signs of life: Yes ☐ No ☐

If yes, move to Neonatal Death ICP, April 2025. Do not continue with this ICP.
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.

Additional Information

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

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

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 ☐ No ☐ N/A ☐ Accepted: Yes ☐ No ☐ N/A ☐
Surgical evacuation of placental tissue	Yes ☐ No ☐ If yes, was it morbidly adherent? Yes ☐ No ☐	
Verbal consent for histopathological examination of the placenta obtained. Preserve in formalin (or other preservative as per local policy) whilst awaiting transport to laboratory ONLY after taking swabs and segment of cord for fetal chromosomal analysis if required. Placenta to be transported with baby if postmortem accepted	Placental pathology offered: Yes ☐ No ☐ N/A ☐ If yes: Accepted (verbal consent) ☐ or Declined ☐ Postmortem accepted: Yes ☐ No☐ N/A ☐	

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: • Hand and foot prints • Foot casts • Name band • Cord clamp						
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) https://www.neonatalbutterflyproject.org/ Provide the parents with the Twins Trust leaflet https://twinstrust.org/bereavement						
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
Kleihauer	All Rh negative women plus if clinical suspicion **irrespective of Rh status**	Maternal blood	Blood Transfusion			
Fetal infection screening		Swab from baby's axilla	Microbiology			
		Placental swab from between amnion and chorion – p10	Microbiology			
Maternal serology	Toxoplasma CMV Rubella Parvovirus B19 Syphilis if not screened at booking	Maternal blood	Virology			
Placental pathology from 14/40	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	Paediatric histopathology, Royal Manchester Children's Hospital for Greater Manchester. Alder Hey Hospital for Cheshire & Mersey.			
Postmortem	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.

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

Selective investigations	Other information	What	Destination	Date	Yes	No
If ≥16+0 weeks external examination of baby	To identify any major fetal abnormalities	External examination				
If clinically suspected maternal infection	If maternal flu like illness, abnormal coloured liquor; prolonged ruptured membranes	Blood cultures lactate, CRP MSU, HVS endocervical swab, throat/nose swab	Microbiology			
If mother symptomatic / clinical suspicion	Herpetic lesions	Herpes simplex virus swab / HSV serology	Virology			
If there is no obvious cause	Maternal thyroid function HbA1c	At delivery	Chemical Pathology			
If fetal anomaly (except for isolated neural tube defect which is unlikely to have a genetic cause) or chromosomal anomaly suspected, or if 3rd consecutive miscarriage	Fetal chromosomes Take 3cm of umbilical cord and place in saline (**not formalin**) for transport. If no identifiable umbilical cord: send 2cm^3 of placenta	3cm of umbilical cord **Do not send more than the required amount of tissue.** If tissue unidentifiable, send maternal blood sample in EDTA tube as well.	Genomics St Mary's Hospital / Liverpool Women's Hospital R22 common aneuploidy screening (by QF-PCR) and microarray. R318 recurrent miscarriage			
If fetal anomalies suspected	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			
If suspected maternal substance abuse	Requires maternal consent	Urine for cocaine metabolites	Chemical Pathology			
If hydrops fetalis	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			
https://www.gov.uk/request-baby-loss-certificate			

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 **no** 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:

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. • Bereavement Midwife • Community Midwife • Maternity Triage • Gynae Assessment Unit • Early Pregnancy Unit						
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 ≥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.					

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			

Cause (if known)

Are Further Investigations Required?				Yes	No
If placental pathology shows maternal vascular malperfusion (MVM), fetal vascular malperfusion (FVM) or villitis of unknown etiology (VUE)	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		
If placental pathology shows chronic histiocytic intervillositis (CHI) or massive perivillous fibrin deposition (MPFD)	Lupus anticoagulant Anticardiolipin and anti-beta2-glycoprotein-1 (anti-B2GP1) antibodies	Maternal blood			
If recurrent miscarriage	Full thrombophilia screen	Maternal blood			
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		

Follow Up Visit Prompt List

General Points Discussed

Pre-pregnancy advice for next pregnancy:

☐ Smoking cessation
☐ Safe alcohol consumption
☐ Illicit drug use
☐ Safe caffeine consumption
☐ Folic acid supplementation
☐ BMI optimisation
☐ Psychological wellbeing
☐ 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

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 intervillositis on placental histology discuss with Rainbow Clinic at St Mary's Hospital or Wythenshawe for commencement of aspirin, LMWH, prednisolone and hydroxychloroquine at 7 weeks gestation after an early viability scan, followed by close ultrasound surveillance. ☐ 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: _____

Notes

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/

Bliss
Family support helpline offering guidance and support for premature and sick babies.
Website: www.bliss.org.uk/

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

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

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

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

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

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

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
Website: www.jbcs.org.uk

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

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

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

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

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

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

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

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/

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

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

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 _____