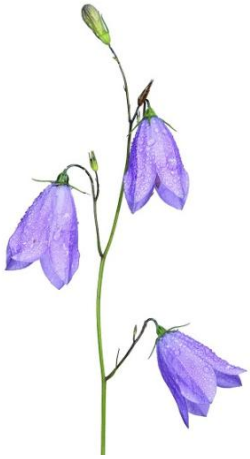
NORTH WEST GUIDELINE

Second Trimester Miscarriage

(formerly Second Trimester Pregnancy Loss)

Version 4

April 2026



To be used from 13+0 to 23+6 weeks gestation with the North West Second Trimester Miscarriage Integrated Care Pathway.

From 24+0 please use North West Management of Stillbirth Guideline, version 5, April 2025.

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

If a baby shows signs of life at ANY gestation, please do not use this guideline, use the North West Management of Neonatal Death guideline. Version 1 April 2025

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

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

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No current national guidance

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These guidelines are available to be adopted across the North West (and anywhere else that finds them useful) in order that parents and their families receive compassionate, family centred and high-quality care if they experience second trimester pregnancy loss. Please note that appendices are geographically oriented and may need editing or localisation. If localising, please reference original authorship.

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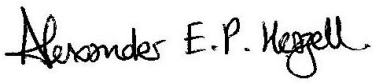
 **Ghazia Saleemi** **Maternity Clinical Lead** Greater Manchester SCN	 **Alexander Heazell** **North West Regional Lead Obstetrician**

Conflicts of Interest: None declared.

Contents

1. Summary / Introduction

The loss of a pregnancy at any gestation is traumatic for the parents, who deserve to be cared for with empathy and compassion. The trauma associated with pregnancy loss extends beyond parents, to everyone involved, including healthcare professionals. The care provided and the role of supporters, counsellors, friends, advocates, carers and clinicians are pivotal to the family's experience and subsequent memories of this time. What we do for families during this time will last a lifetime, so it is important that we get it right.

This guideline has been written by a multi-disciplinary team of professionals working in maternity units across the North West. This guideline and associated Integrated Care Pathway align with the principles of the Sands National Bereavement Care Pathway. We use the terms 'woman' and 'women' but the guideline also applies to people who do not identify as women but are pregnant or have given birth.

2. Purpose

The purpose of this guideline is to describe optimal care in the management of women who experience second trimester miscarriage between 13+0 and 23+6 weeks.

For stillbirth (from 24+0 weeks) please refer to the **North West Management of 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.

If 22+0-23+6 weeks gestation and the fetal heart beat is present on admission please contact the neonatal team for joint counselling with the obstetric team. See **Perinatal Management of Extreme Preterm Birth Before 27 Weeks of Gestation, A BAPM Framework for Practice (2026).**

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

3. Guideline Scope

This guideline is written to support an integrated care pathway to facilitate optimal care of families who experience second trimester pregnancy loss. Whilst this guideline does not cover the management of threatened miscarriage or preterm pre-labour rupture of membranes (PPROM), it would be appropriate for use should either of these conditions result in miscarriage before 24 weeks gestation. Please refer to NW Regional Guideline for Preterm Pre-labour Rupture of Membranes (PPROM) and NW Regional Guideline for Preterm Birth. This guideline is also relevant to situations where it seems the mother will birth her baby before 24 weeks gestation and it is uncertain whether the baby will be born alive.

4. Responsibilities

Midwives, obstetricians, neonatologists, gynaecologists, specialist gynaecology nurses, health care assistants, counsellors, perinatal histopathologists, mortuary staff, early pregnancy loss and bereavement teams caring for people who experience second trimester miscarriage.

5. Guidance

5.1 Introduction

Spontaneous miscarriage is the most common complication of pregnancy, occurring in about 15% of recognised pregnancies [1, 2]. The miscarriage rate is reduced to approximately 1% if a live fetus has been identified by ultrasonography at 10 weeks gestation in a normal population.[3] Miscarriages occurring in the second trimester of pregnancy are less common and often unexpected. The incidence of miscarriage in the second trimester varies depending on the gestational age in weeks that is used in definitions and also whether the pregnancy has been dated and evaluated using ultrasound. Data on the frequency of second trimester pregnancy loss is not routinely collected in the UK. In low-risk women the risk is approximately 0.5%.[4]

The loss of a pregnancy at any gestation is traumatic for the parents, who deserve to be cared for with empathy and compassion[5]. Commenting about mid-trimester loss a Sands report noted:

> "Poor or insensitive care at this traumatic time adds significantly to parents' distress. Good care should be universal and should not depend on where a mother happens to live or to be cared for."[6], [7]

This guideline has been written by a multidisciplinary team of professionals working in maternity units across the North West. In the absence of a UK guideline, Clinical Practice Guideline 29, The Management of Second Trimester Miscarriage from the Institute of Obstetricians and Gynaecologists and Royal College of Physicians of Ireland was reviewed, along with the relevant sections of the RCOG Green Top Guideline No 55, Late Intrauterine Fetal Death and Stillbirth. [8], [9]

This guideline is written to support the Second Trimester Miscarriage integrated care pathway to facilitate optimal care for families who experience second trimester miscarriage. Whilst this guideline does not cover the management of threatened miscarriage or preterm pre-labour rupture of membranes (PPROM), it would be appropriate for use should either of these conditions result in miscarriage before 24 weeks gestation. Between 22 weeks and 23+6 weeks where it is uncertain whether the baby will be born alive, please refer to Perinatal Management of Extreme Preterm Birth Before 27 Weeks of Gestation, A BAPM Framework for Practice (2026)[10] and Recognising uncertainty: an integrated framework for palliative care in perinatal medicine | British Association of Perinatal Medicine (2024).[11]

5.2 Presentation, Diagnosis and Immediate Care

In women who present with abdominal pain and vaginal bleeding or spontaneous labour, the diagnosis may be clinical. However, many do not present in this way in the second trimester. Women may present with a history of ruptured membranes or very subtle signs such as increased vaginal discharge or feeling pressure in the vagina. In some circumstances the woman may be asymptomatic and the diagnosis of fetal death in utero made during a routine ultrasound examination.

A thorough clinical history and physical examination with informed consent are important in the assessment of women presenting with symptoms or signs suggestive of miscarriage. An obstetric history should be obtained including known uterine anomalies, previous second trimester pregnancy loss or cervical surgery including cervical suture and Caesarean section at full dilatation. Other risk factors for second trimester miscarriage include advancing maternal age, black ethnicity, smoking, excessive alcohol or caffeine consumption and obesity.[12]

Clinical examination should include the woman's vital signs and calculation of the Maternity Early Warning Score (MEWS) with appropriate escalation of any concerns. Perform a careful abdominal examination with the woman's consent, assessing for any uterine tenderness or contractions. Sterile speculum examination should be performed by a trained individual in an appropriate environment, with a chaperone, respecting the woman's privacy and dignity. Assess the cervix, look for any vaginal bleeding or pooling of liquor. A high vaginal swab should be sent for microbiological culture and sensitivity. If the membranes are ruptured, digital vaginal examination should be avoided where possible to minimise the risk of ascending infection. If the cervix needs to be assessed with a view to induction, vaginal examination in the presence of ruptured membranes should be deferred until induction so that the examination to birth interval is minimised.

When fetal death in utero is suspected and the woman is not actively labouring this **must** be confirmed by two-dimensional ultrasound at the earliest opportunity. If the diagnosis is suspected in the community, the woman should be immediately asked to attend the hospital for confirmation, accompanied by her preferred support persons. If the woman is clinically well, she may wish to delay the scan until her support persons are present.

The optimal method to confirm fetal death in utero is an ultrasound scan performed by trained sonographers. However, out of hours a practitioner with appropriate training may use a portable ultrasound machine. The fetal chest should be imaged in the transverse plane. A four-chamber view of the heart should be identified, though this may be difficult at earlier gestations. Colour flow Doppler is useful to verify the absence of heart activity. It is advisable to obtain a second opinion from a suitably trained person, although it is recognised that this may not always be possible in emergency situations. Sonographers should explain what they are doing during the ultrasound scan as long silences may be very difficult for the parents. The parents should be asked if they wish to see the screen. If the sonographer needs time to concentrate, it may be helpful to say, "I am going to be quiet for a moment so that I can concentrate on the screen." Staff should be aware that parents are often highly sensitive to non-verbal messages and body language. Unit 3: Considering language and terminology - The Miscarriage Association.

The Second Trimester Miscarriage Integrated Care Pathway should now be commenced.

5.3 Breaking Bad News

This is a very sensitive situation best managed by a senior clinician, supported by the nurse or midwife caring for the family. Clinicians should ideally have completed training in breaking bad news and sensitive communication. National Bereavement Care Pathway training modules are available at https://www.e-lfh.org.uk/programmes/national-bereavement-care-pathway/.

Parents remember for a long time the way in which the news of their baby's death was given to them. Therefore, plenty of time must be allowed so that information is not given in a hurried fashion. If the woman is unaccompanied, an immediate offer should be made to call her partner, relative or friend. If English is not the first language of a family ideally a face-to-face interpreter should be used. A warning must be given to the interpreter as to the content of the conversation.

Practice points for sharing bad news

- The discussion should take place in a suitable environment, ensuring privacy.
- Offer refreshments to the family.
- Do not be afraid to show and say how sorry you are. Parents appreciate it if you show your emotions.
- Partners should be included in all discussions, unless the mother declines.
- Plenty of time must be allowed when breaking the news of the baby's death.
- Ensure you know the parents' names.

If performing an ultrasound and the fetal heartbeat is absent, the language used to convey this to the parents should be clear. A suggested statement is: "I'm terribly sorry, I can see your baby's heart clearly and it is not beating, which means your baby has died."

The Sands leaflet 'Sensitive and effective communication' gives some helpful advice. Discussions should be culturally sensitive and should aim to support maternal/parental choice. Consider contacting the on-call lay chaplain or appropriate religious leader for emotional support or/and religious care.

Parents should be offered written information to supplement discussions. The Miscarriage Association: Second Trimester Loss (November 2023) is suitable up to 16 weeks. The RCOG leaflet When your baby dies before birth may be more suitable after 16 weeks (October 2024).

Following the diagnosis and confirmation of fetal death in utero the parents must be given time to absorb and accept this news. Staff should be aware of the range of reactions that parents may have when receiving this news and offer emotional support. Parents may be surprised and shocked that they will still have to go through labour. They may also be surprised that they may go home whilst awaiting birth and that there may be a delay in giving birth to their baby who has died. It is vital that the parents are fully informed. Questions should be welcomed and encouraged. Naturally, parents want to know why their baby has died. This may not be known at this stage, but parents must be assured that it is

not their fault and that investigations may be helpful. Parents have reported that indifferent attitudes from doctors and midwives and insensitive remarks and actions are remembered for a long time after the loss of their baby. Conversely, just a few thoughtful, heartfelt, caring words and letting parents know how sorry you are can last a lifetime.

Informed Choice

Parents should have a detailed discussion about management options and their wishes and preferences should be explored. There are many difficult and important decisions for parents to make as they journey through pregnancy loss for example whether to have their labour induced, whether to accept a postmortem, how to remember their baby. Clinicians should facilitate informed choice wherever required, using the BRAIN (benefits, risks, alternatives, intuition, nothing) decision support tool (see ICP page 5).

Although care should be taken not to overload the parents with too much detail initially, it is important to give adequate information. Where possible, it is good practice to have an early discussion about what to expect in terms of induction, analgesia, birth, appearance of baby, memory boxes and other mementos. Parents also want to know more about investigations which may be offered and funeral arrangements. Some mothers will want to go home to see family members whilst others may wish to commence the induction process as soon as possible. If the mother had been feeling fetal movements before diagnosis, then the possibility of feeling passive movements should be discussed with her and a 24-hour contact number should be given.

5.4 Psychological Support

Pregnancy loss is associated with short term and chronic anxiety and depression not only in the mothers but also partners, fathers, siblings and other family members. Feelings of grief and loss (bereavement reactions) are very common and expected. It is important to ensure that the family are well supported throughout the hospital stay and beyond, with as much continuity of care and carer as possible. Every woman who experiences a pregnancy loss is at risk of depression, but those with psychiatric illness or from a vulnerable social group are at particular risk. As soon as practically possible, involve your Trust's Bereavement Midwife, Bereavement Nurse or Counsellor to provide ongoing support.

Place of care

Women should be admitted to a place of care where their emotional and physical needs can be taken into account without compromising safety. Whilst in hospital the parents should be cared for with respect and dignity, in a single room to ensure privacy during this difficult time. Ideally, parents should be cared for in a different environment from mothers with healthy babies. It is recommended that women who are 16 weeks or more should be cared for in maternity facilities, though there are local variations in place of care at earlier gestations. In a maternity setting, one-to-one care should be facilitated at least for the first 24 hours to support the mother and the family and complete necessary procedures and notifications. It is recognised that, whilst ideal, this may not always be possible during times of high activity in the maternity unit. The partner/family should be able to remain with the mother as long as she wishes.

Pastoral and spiritual care

Health care professionals caring for grieving families should provide compassionate, individualised care, ensuring cultural sensitivity. Ask the parents if there are any 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. Parents may want the opportunity to see their own religious leader or a member of Pastoral Care Chaplaincy Services. This should be facilitated by maternity unit staff and offered to all families even if they do not have a specific faith.

For more information on religious customs see neonatalnetwork.co.uk/ReligiousPractices. If caring for a Jewish family please see GMEC Miscarriage or Stillbirth for Jewish Parents SOP (September 2022), published by the Jewish Community in Manchester, together with Misaskim, Tommy's and Manchester University Foundation Trust in 2022.

5.5 Multiple Pregnancies

Approximately 1.5% of pregnancies in the UK are twins or higher order multiples, with numbers rising significantly over the past 20 years due to increasing maternal age and assisted conception. Perinatal loss occurs more frequently in multiple pregnancies than singleton pregnancies. At gestations under 24 weeks the fetal loss rate for monochorionic twins is estimated to be 14.2% compared with 2.6% for dichorionic twins.[13] [14]

Clinicians should appreciate the complexity and mixed emotions of parents who experience the loss of one or more fetuses with a surviving twin or higher order multiple. The timing and mode of birth will depend on chorionicity, gestation, the presentation of the fetuses and the wellbeing of the surviving baby/babies. Specialist advice should be sought from the Multiple Pregnancy Lead or Fetal Medicine Unit.

Parents will require support throughout the pregnancy and birth and bereavement care. Parents want to talk about the baby that has died and to acknowledge that they were twins. Some parents may wish to take photographs of the babies together so this should be discussed and offered. The Butterfly Project supports families who have lost a baby from a multiple pregnancy. E-learning for professionals 'Bereavement from a multiple pregnancy' and supporting resources can be found neonatalbutterflyproject.org/guidelines

Parents may also wish to access the Twins Trust resources twinstrust.org/bereavement.

The timing of investigations may need to differ in a multiple pregnancy if the pregnancy is continuing with one or more healthy fetuses. See investigations at diagnosis.

5.6 Termination of Pregnancy for Maternal Health Reasons

A decision to end a pregnancy due to maternal health with the intention of resulting in fetal demise (pre-viable gestational ages) constitutes a termination of pregnancy by law. Please see the North West Termination for Fetal Anomaly Guideline for legally required documentation and procedures.

5.7 Medical Management of Fetal Death In Utero

This section will assist nurses, midwives, obstetricians and gynaecologists in the medical management of second trimester fetal death in utero, once a robust diagnosis has been made. In certain clinical situations the maternal medical condition will necessitate expediting the birth. Problems related to delayed birth include intrauterine infection if the membranes are ruptured or disseminated intravascular coagulopathy if the fetus is dead for more than 4 weeks[15].

Investigations to be performed at presentation in a singleton or multiple pregnancy

- FBC, clotting screen, group and save.
- Kleihauer (irrespective of maternal blood group), to assess for and quantify feto-maternal haemorrhage especially if clinical suspicion e.g. vaginal bleeding or other sensitizing event.
- **Anti D should be administered at diagnosis according to local policy if the woman is Rh negative and the baby known to be Rh positive or if fetal Rh status is unknown.**
- Infection screen (HVS, LVS, endocervical swabs, throat swabs, MSSU, CRP, blood cultures) should be performed if maternal infection is suspected, particularly in the presence of pyrexia, flu-like symptoms, abnormal liquor or rupture of membranes.
- Infection is more likely to occur when the cervix is dilated, if the membranes are ruptured or if the uterine contents have protruded through the cervix.
- Maternal antibiotic administration should be considered on an individual basis.
- For investigations performed after birth see 5.16 Investigations

Additional investigations to be performed at presentation in a multiple pregnancy

- Though rare, dichorionic twins can be discordant for infection so in addition to the above a TORCH screen should be taken at diagnosis of co-twin demise in a DCDA pregnancy with selective fetal growth restriction (sFGR).
- In monochorionic twins the cause of demise is invariably due to the shared placenta so additional investigations are not required at the time of diagnosis.

Timing of Birth

Urgent birth may be required if there is **sepsis, significant bleeding** or in some cases of **ruptured membranes.** The method of induction under these circumstances should be customised to the presenting condition and other patient factors including past obstetric and past medical history. If the above have been excluded, a senior clinician should discuss the timing and process with the mother and offer a choice of induction or expectant management. If expectant management, arrangements for review should be made.

- If induction is delayed >48 hours repeat FBC and clotting screen weekly
- Advise that with expectant management the appearance of the baby may deteriorate
- All mothers should be given a 24-hour contact number for the relevant ward or clinical area if they are managed as an outpatient for any time between diagnosis and birth

- Advice should be given to return to hospital should the mother experience symptoms such as abdominal pain, vaginal bleeding or have any concerns about her well-being
- Vaginal birth is the recommended mode of birth at gestations under 24 weeks.

Extremely rarely, a hysterotomy may need to be considered due to:

- Unsuccessful induction
- Deteriorating maternal condition (e.g. haemorrhage or sepsis)
- Multiple previous Caesarean sections, morbidly adherent placenta or previous trachelectomy with trans-abdominal cerclage.

5.8 Drug Information

A combination of mifepristone and misoprostol is recommended for induction in second trimester miscarriage. The combined use of mifepristone and misoprostol is not only safe but also has an average time-to-birth interval less than other induction regimes[16] [17]

Mifepristone

This anti-progestogenic steroid is used as pre-treatment. It facilitates uterine response to subsequent administration of a prostaglandin and takes time to work so is usually given before prostaglandin**.** Women should be observed when taking this medication.

Contraindications – uncontrolled severe asthma, chronic adrenal failure, acute porphyria.
Cautions – asthma, risk factors for cardiovascular disease, prosthetic heart valves or endocarditis and haemorrhagic disorders.

Misoprostol [18](prostaglandin E1)

In the second trimester of pregnancy this is as effective as other prostaglandin preparations[19] Advantages over other synthetic prostaglandin analogues are its low cost, long shelf-life, lack of need for refrigeration and worldwide availability.

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

Side effects include fever, nausea, vomiting, abdominal cramping, and diarrhoea. **These are less common if the tablets are given vaginally.** Serious complications such as uterine rupture, major haemorrhage and cervical tear are rare.

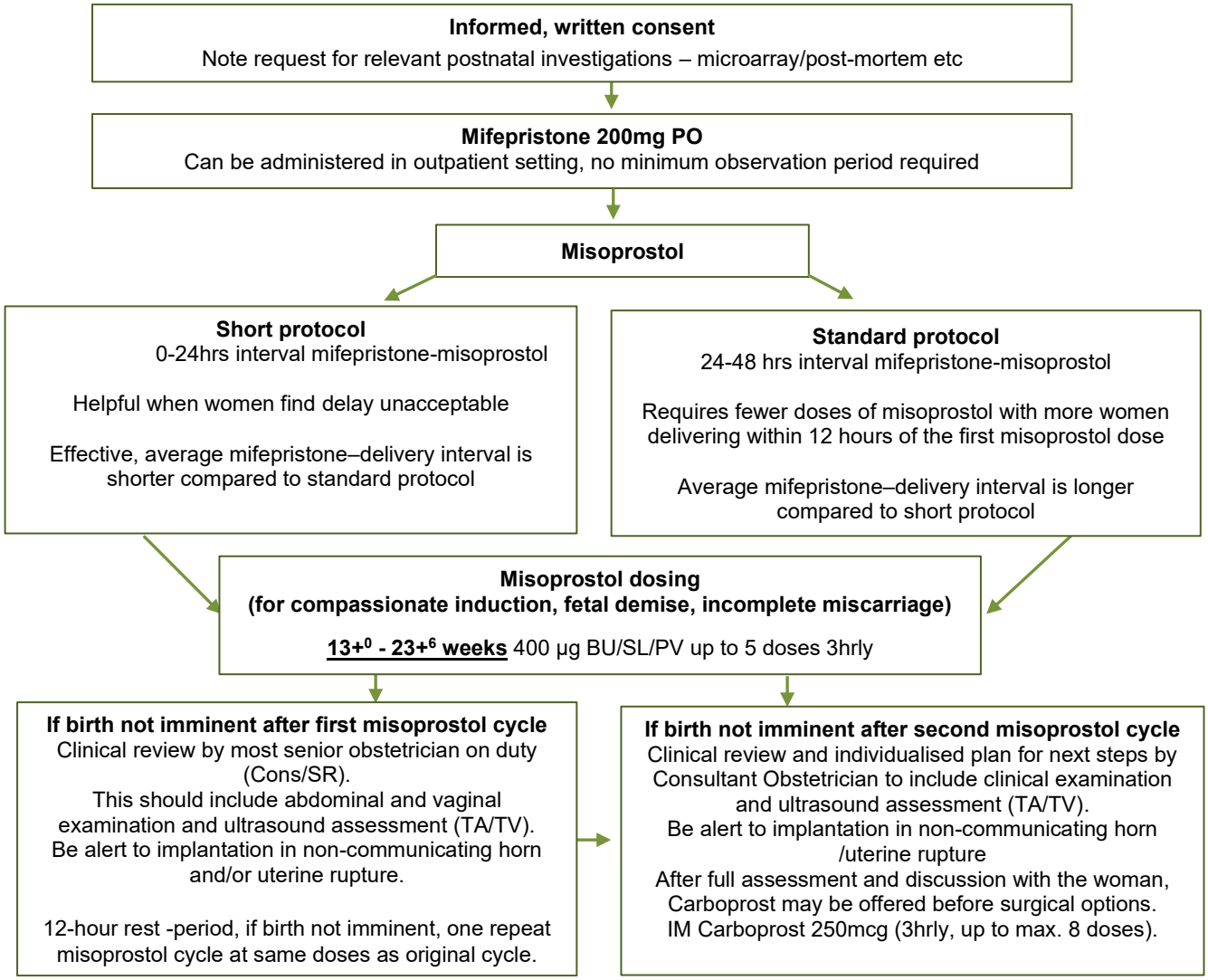
5.9 Pre-Induction

At all gestations, regardless of whether there is a uterine scar, a single dose of **200 milligrams oral mifepristone** is given after which the mother should be allowed home wherever possible**.** Arrangement should be made for admission to hospital 24 hours to 48 hours later, or sooner, depending on the woman's preference. The woman should be advised to return to hospital if she experiences pain and/or bleeding or has other concerns.

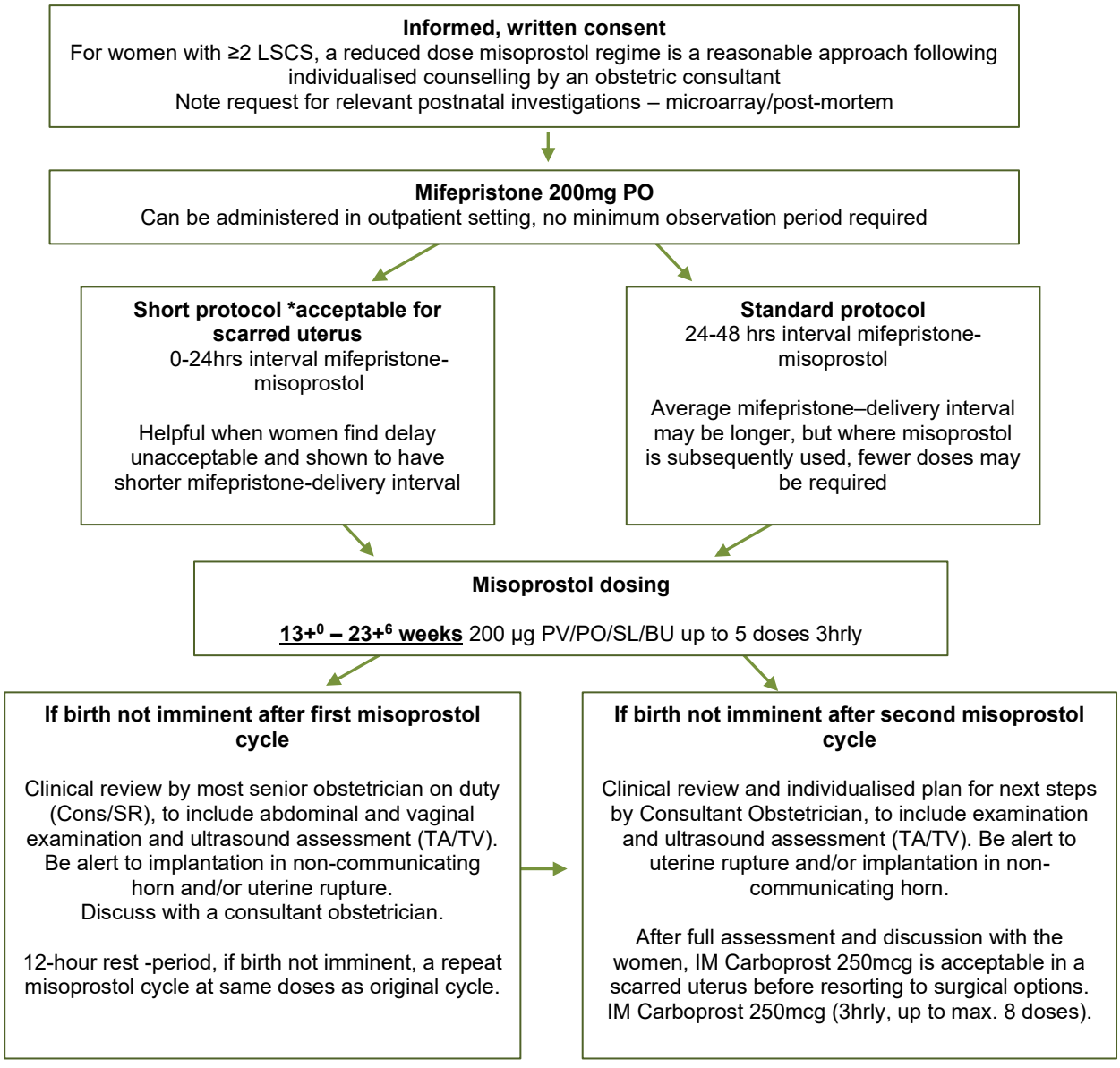
5.10 Induction for Fetal Demise

Vaginal assessment should be performed prior to administering misoprostol. The vaginal route is recommended due to the lower incidence of side effects. If the vaginal route is not appropriate due to vaginal bleeding, alternative routes are buccal, sublingual or oral.

Unscarred Uterus			
Gestation	**Medication**	**Dose**	**Comments**
Day 1 13+0-23+6 weeks	Mifepristone	200 milligrams single dose	PO
0-48 hours later	Misoprostol	400 micrograms PV 3 hourly (5 doses)	Less side effects with vaginal route



Scarred Uterus			
Gestation	**Medication**	**Dose**	**Comments**
Day 1 13-23+6 weeks	Mifepristone	200 milligrams single dose	PO
0-48 hours later	Misoprostol	200 micrograms PV 3 hourly (5 doses)	Lower incidence of side effects with vaginal route



Misoprostol is safe to use below 28 weeks gestation with a history of Caesarean birth. The risk of uterine rupture with misoprostol, although small, is increased in women with one or more previous Caesarean sections or other uterine scars. This should be discussed with the parents. The guideline development group recommend that the misoprostol dose should be halved for women with a previous caesarean section (see flowchart above). All staff should be vigilant to clinical features suggestive of uterine scar dehiscence or rupture, such as maternal tachycardia, atypical pain, vaginal bleeding, haematuria or collapse.

Management of women when there is no response to the first course of misoprostol

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

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

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

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

Surgical Management

Surgical management may be appropriate for certain women in specific individual circumstances but is not routinely performed in the North West after 13 weeks. Dilatation and evacuation may be appropriate if there is a skilled clinician available to perform the procedure. Parents should be informed that surgical procedures may affect the investigations which can be offered or the quality of the results. At later gestations, hysterotomy may be offered if medical management is not appropriate or has not been successful.

Women with ruptured membranes

There is no evidence in the literature as to an optimal regime for induction when the cervix is dilated and/or the membranes are ruptured. Although logically in such situations avoidance of multiple digital examinations may reduce the risk of ascending infection, there is a lack of evidence to guide practice. In such circumstances, if the clinician or patient wishes to avoid vaginal misoprostol, intravenous oxytocin may be considered after discussion with a Consultant Obstetrician. A randomised prospective trial has shown that oxytocin is as efficient as misoprostol in inducing labour in second trimester miscarriage. However, the oxytocin regime has a longer mean time to birth.[20]

5.11 Extreme Preterm Birth 22+0 to 23+6 Weeks

When it appears that a mother will give birth at a very early gestation, the obstetric history, antenatal course, any significant maternal disease and important fetal factors (e.g. early onset fetal growth restriction, multiple pregnancy, fetal anomalies) must be considered carefully with multi-disciplinary input. Antenatal management planning should be individualised, involving parents and joint counselling from the obstetric and neonatal teams. Some cases will benefit from involvement of fetal medicine and maternal medicine specialists. Dependent on individual maternal-fetal factors, gestational age and the risk profile of the baby, options may include comfort focused care or survival focused care.

Less than 22+0 weeks

Parents should be counselled by the obstetric team that their baby cannot survive at this gestation thus survival focused care should not be offered and comfort focused care should be recommended. Parents should be informed that their baby may attempt to gasp and move when born, they will be kept warm and comfortable, treated with respect and dignity.

22+0 and 23+6 weeks

Most babies between 22+0 and 22+6 weeks gestation and some babies between 23+0 and 23+6 weeks gestation with unfavourable risk factors are considered to have a >90% chance of either dying or surviving with severe impairment if liveborn and survival focused care is instituted. It would be in the best interests of the baby to provide comfort focused care, and standard practice not to offer survival focused neonatal management. However, if the baby is likely to be born alive, the parents should be informed. It is important that a doctor sees the baby alive, in order to be able to issue a death certificate.

Uncertain gestation

If the gestation is uncertain, or where there is parental request for survival focused care, they should be given the opportunity to discuss management with the neonatal team. A plan of care should be agreed and documented. This would not automatically mean that the survival focused care is offered, the final decision lies with the neonatologist present at the birth after careful assessment of the baby. Survival focused care may be appropriate if baby is born vigorous and of an apparently good birth weight.

In an emergency presentation, particularly where a woman is unbooked and the pregnancy undated, the clinical team should proceed with caution. Where a baby is born and appears peri-viable or viable, the neonatal team should be crash bleeped, a senior registrar or consultant should attend and active care should be provided until a full assessment of the baby has been made by a senior neonatal clinician. If, after this assessment, the gestational age is thought to be less than or equal to 22+6 weeks, and/or other significant factors are identified, the neonatologist should discuss with the parents to agree a plan where survival focused care may not be appropriate, and comfort focused care recommended.

For further details please see Perinatal Management of Extreme Preterm Birth Before 27 Weeks of Gestation. A BAPM Framework for Practice, February 2026
Recognising uncertainty: an integrated framework for palliative care in perinatal medicine | British Association of Perinatal Medicine (2024)

Management of a baby born with signs of life where comfort focused care is most appropriate

Where possible, discuss with the parents before the birth that family centred comfort focused care will be offered, with opportunities to create positive memories of their baby. Reassure parents that their baby will be treated with dignity and respect. The parents should be given the option of seeing and holding their baby. If the parents do not want to see or hold their baby, the baby should be wrapped to keep them warm and be cared for in the most appropriate location for the family. This will depend on local facilities. Explain to the parents where the baby will be and that a healthcare professional will remain with the baby but that no medical treatment will be given.

Babies born with signs of life should be seen by a doctor at the earliest opportunity. If a live birth and subsequent neonatal death, the death must also be confirmed and time of death documented by a doctor. **Please refer to the North West Management of Neonatal Death Guideline for further management including referral to the coroner or medical examiner. This guideline is not applicable for babies born with signs of life.**

5.12 Care During Labour and Birth

Women with a second trimester pregnancy loss in spontaneous labour or following induction for fetal demise should be admitted to a place of care where their emotional and physical needs can be taken into account without compromising safety.

A Consultant Obstetrician or Gynaecologist should be made aware of the admission, depending on gestation and place of care. Efforts should be made to provide continuity of care and carer. Care should be given by an experienced midwife or nurse. In a maternity setting, this should be the same as normal care in labour as per trust policy including use of the bereavement specific partogram in the corresponding Integrated Care Pathway (page 8-9). Ideally one to one care should be facilitated at least for the first 24 hours to support the mother and the family and complete the necessary procedures and notifications, though this is aspirational and may not always be possible during times of high activity in the maternity unit. The birthing partner/family should be able to remain with the mother as long as she wishes.

Recommend that the woman uses a bedpan whilst using the toilet during the induction process and during labour, especially at earlier gestations.

Analgesia

Adequate analgesia should be offered. All usual modalities should be made available, including epidural at later gestations (unless there are concerns regarding sepsis or coagulopathy). If intramuscular opiate analgesia is chosen, then diamorphine should be used in preference to pethidine as it provides better analgesia. Fentanyl patient-controlled analgesia (PCA) is also an acceptable choice in pregnancy loss, as there is no concern about accumulation in the baby.

Sepsis

Women with sepsis should be treated with intravenous broad spectrum antibiotics after sepsis screening investigations have been performed. Please refer to local antibiotic policy.

Women with a second trimester loss and GBS colonisation of the vagina **do not require** antibiotic prophylaxis in labour.

Third stage

The third stage should be managed actively in accordance with local guidance. Syntometrine (ergometrine 500 mcg/5IU oxytocin) 1 ampule IM or oxytocin 10 units IM can be used in a maternity setting.

Women should be informed that there is a higher incidence of retained products of conception (RPOC) compared to first trimester miscarriage especially at gestations of 13-20 weeks. North West regional audit data (2019 and 2020) suggests that the incidence is 20%. A low threshold for evacuation of retained products of conception (ERPC) should therefore be adopted if the placenta or membranes appear incomplete or if the woman experiences excessive bleeding.

If there is a delay in delivery of the placenta by more than 30 minutes after the fetus the bladder should be emptied and an additional dose of misoprostol can be given. If there is a delay in completion of the third stage of more than one hour, surgical intervention should be considered. Informed written consent should be sought from the woman after explaining uncommon surgical risks including uterine perforation (1%), cervical tears, intra-abdominal trauma (0.1%), haemorrhage and infection. Theatre and recovery staff should be informed of the pregnancy loss and the need to keep the placenta for swabs and/or histology.

Thromboprophylaxis

A thromboprophylaxis risk assessment should be performed. Whilst miscarriage and termination do not increase the risk of venous thromboembolism per se, associated complications may increase the risk (e.g. haemorrhage, sepsis.) Low molecular weight heparin should be prescribed if required as per local guidance. If the woman has disseminated intravascular coagulation (DIC), once successfully managed discuss the initiation of thromboprophylaxis with a haematologist.

Anti-D Prophylaxis

Anti-D should be administered to non-sensitised Rhesus negative women after birth as per national guidance, unless non-invasive prenatal testing for fetal Rhesus status has been performed and the fetus is known to be Rhesus negative. If the Kleihauer is positive the amount of feto-maternal haemorrhage will be quantified and guide further anti D dosing.

5.13 Care of Baby

The individual cultural and spiritual needs of each family should be identified and accommodated. Assistance should be given to facilitate the grieving process including empathic care, appropriate literature and contact telephone numbers.

Contact with baby

Parents should be given the option of seeing and holding their baby whatever the gestation. Some parents may wish to see and hold their baby immediately after birth, others may prefer to wait and some will decline; their decision should be respected. At earlier gestations parents should be prepared for their baby's appearance. Parents are free to change their minds and can ask for their baby to be brought to them whenever they feel ready. Parents may wish other family members to be given opportunity to see/hold baby.

Parents should be offered the use of a cooling cot or cuddle cot if available and appropriate. https://flexmort.com/cuddle-cot/ or https://abigailsfootsteps.co.uk/professionals/cold-cots-for-hospitals/

Staff should inform parents that the gender of the baby may not be easily identified at earlier gestations. Hence, in cases of uncertainty, the fetal gender should not be assigned. The parents may decide to choose a neutral name for baby or wait until the gender is confirmed by genomics or at postmortem.

Mementos

Mementos include hand and footprints (though these may not be possible at earlier gestations), cord clamp, identity band. Most parents welcome these tokens and they can be presented in memory boxes. Many charities offer memory boxes to record and store mementos obtained (for example 4Louis, SIMBA). If parents are not ready to look at mementos and/or photographs, these can be sealed in an envelope or memory box for the parents to open in their own time.

Photographs of baby

Photographs of the baby are valuable and can be taken with the parents' own camera, with the hospital digital camera, or by medical photography. If there is a multiple birth, offer to take photographs of the babies together and/or separately

Taking photographs with the hospital digital camera requires parental verbal or written consent. Identification of the start and end of a series of photographs must be performed. Similarly, verbal or written consent is required for photographs to be taken by medical photography.

The Butterfly Project - supporting parents who have lost a baby from a multiple pregnancy

Parents who have suffered a bereavement from a twin pregnancy (or higher order multiple) face the difficult challenge of dealing with the bereavement, while often simultaneously feeling anxious about the prognosis for surviving multiples. They differ from parents who

have lost a singleton in many ways, but one important difference is that parents who have lost a twin born prematurely often remain in hospital for weeks or months while the surviving twin is cared for on SCBU.

Staff attitudes, behaviours and actions have a huge impact on parents both in the short and longer term. Generally, parents appreciate it when staff acknowledge that a surviving baby is a twin, and value the importance of knowing about the circumstance of the loss (e.g. when did it occur) as well as the name of the baby who died.

The Neonatal Research Network https://www.neonatalresearch.net/butterfly-project.html have developed two concepts:

1. A small sticker of a butterfly that can be put on the front of the mother's notes, including handheld notes, where the loss happens before birth. Where the loss happens after delivery the butterfly could be placed on the medical notes of the surviving twin. However, check with your hospital that this is allowed.

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

For more information see appendix 6.

5.14 Postnatal Care of Mother

Psychological support

All parents and siblings should be offered bereavement support and counselling; this could be from a Bereavement Support Midwife, Specialist Nurse or Midwife or counsellor who can provide support from diagnosis of the miscarriage until well into the postnatal period. They will also be able to offer continuity and psychological support in subsequent pregnancies. Information of support organisations and groups should be offered. If the woman has ongoing psychological concerns or a known psychiatric disease the General Practitioner and Health Visitor should be made aware of this.

As soon as practically possible, involve your Trust's Bereavement Midwife, Bereavement Nurse or Counsellor to provide ongoing support.

An additional online resource which may be useful for parents, family, friends and health professionals is "Babies born too soon: Parents' experiences of losing a baby at 20-24 weeks of pregnancy" https://healthtalk.org/introduction/losing-baby-20-24-weeks-pregnancy/

Lactation

If 18+0 weeks gestation or over, suppression of lactation should be discussed. This could include natural suppression with supportive measures. Cabergoline 1 milligram may be

administered orally as a single dose, unless there is maternal hypertension/pre-eclampsia/puerperal psychosis. For rarer contraindications see ICP p19.

Some mothers choose to continue to express milk following the loss of their baby. While this option does not suit everyone, some families find comfort in continuing to express and donate. Healthcare professionals should discuss the option of milk donation with bereaved families to help make a decision that feels right for them. The Memory Milk Gift Initiative was founded in June 2021 with the aim of improving services offered to bereaved families donating to the Milk Bank at Chester (MBAC), the largest NHS Milk Bank in England.

Further information can be found at https://www.milkbankatchester.org.uk/donationafterloss/. A free, two-hour Future Learn course is available to NHS staff. Lactation and Loss; Choices for Bereaved parents Learninghub.nhs.uk/Lactation After Loss: Choices for Bereaved Parents.

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

There are also charities / companies offering an option for parents to have milk jewellery created as a lasting memento of their baby.

Future Appointments

All outstanding appointments with midwifery, ultrasound or obstetric services should be cancelled to avoid potential upset. Please reassure the parents that they do not need to cancel future appointments themselves.

Contraception

Contraception should be discussed and where possible be provided as per local policy before discharge home.

5.15 Reporting Process

Miscarriage

If a baby is born without signs of life before 24+0 weeks gestation this is classified as a miscarriage. In the absence of signs of life, birth registration is not legally required. However, the parents may wish to apply for a certificate to commemorate their baby and recognise their grief and loss. Inform families that the certificate may be requested from https://www.gov.uk/request-baby-loss-certificate.

Multiple Pregnancies

When fetal demise in a multiple pregnancy has been confirmed by ultrasound before 24 weeks but birth is after 24 weeks, such as in the case of a single twin demise, fetus papyraceus or multifetal pregnancy reduction, the demised fetus should **NOT** be registered as a stillbirth with the registrar, though delivered from the mother after 24 weeks[21].

Reporting to SPEN

The NHS launched a new system in November 2025 known as Submit a Perinatal Event Notification (SPEN) this is a web-based portal designed to streamline the notifications of qualifying perinatal safety events to three national organisations:

- MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK)
- Maternity and Newborn Safety Investigations (MNSI).
- NHS Resolution Early Notification (NHSR EN) scheme.

MBRRACE-UK

MBRRACE-UK is a national collaborative program of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths. Second trimester pregnancy losses eligible for notification are:

- **Late fetal losses** – the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred.

Each maternity unit will have a designated person responsible for reporting relevant fetal losses to MBRRACE-UK, for example the bereavement midwife. MBRRACE-UK notifications should be completed within 7 working days as per National Perinatal Epidemiology Unit, through the SPEN system https://notify-perinatal-events.nhs.uk/. With the implementation of SPEN, the only process that will change is the initial notification for deaths in England. Users will still need to log into the MBRRACE-UK/PMRT system www.mbrrace.ox.ac.uk to complete surveillance as well as manage cases, conduct PMRT reviews, download reports, and use the Real Time Data Monitoring (RTDM) tool.

Perinatal Mortality Review Tool

Late fetal losses from 22+0 weeks meet the criteria for a multidisciplinary review, using the perinatal mortality review tool (PMRT) which supports objective, robust and standardised local reviews of care. https://www.npeu.ox.ac.uk/pmrt/about-us/the-pmrt-tool This is to provide answers for bereaved parents about whether the care that they and their baby received was appropriately safe and personalised or whether different care may have changed the outcome.[22], [23] Parents should be told about this perinatal review process and given a letter of explanation. Parental questions should be invited and if there are none initially, parents should be asked a second time. Both dates should be recorded in the maternal records. Parents will be supported throughout the process by the bereavement midwives. Trust governance and Duty of Candour processes should be followed. PMRT reviews must involve all care providers, so if antenatal care was provided in a different unit than the one where the miscarriage occurred the relevant providers should be notified and be involved in the review. The review must have commenced by 4 months following the loss and be completed by 6 months. The report should be fed back to the parents.

5.16 Investigations

The aim of investigation is to determine the cause of miscarriage. Where there is a fetal anomaly and the cause of death is known, further investigations may not be necessary. Advice should be sought from the woman's named Consultant in the Fetal Medicine Unit or the Consultant on call.

Investigations are closely aligned with the investigations following a stillbirth. There should be clarity as to who is responsible for reviewing and acting upon the results of tests. Establishing a cause-and-effect relationship may be difficult. However, depending on how extensively the woman wishes to be investigated, the cause may remain unexplained in up to half of cases.

Causes include fetal structural abnormalities, chromosomal abnormalities, maternal uterine anomalies, chorioamnionitis, placental dysfunction and cervical insufficiency or incompetence[10]. Infection has been implicated in 10-25% of second trimester pregnancy losses.[24] Many infectious agents have been suggested, including bacteria, spirochetes, protozoa, viruses and fungi. Bacterial vaginosis has been associated with second trimester pregnancy loss and whilst treatment may not reduce the risk in a low risk population, treatment may reduce the risk in women with a history of preterm birth.[25],

Chorioamnionitis may be subclinical, often diagnosed on placental histopathology in the absence of a clinical diagnosis.[26]

Many studies have shown weak associations between pregnancy loss after 20 weeks gestation and Factor V Leiden mutation, protein S deficiency and the prothrombin G2021 mutation.[27] Antiphospholipid antibodies can cause placental thrombosis resulting in an increased risk of second and third trimester pregnancy loss.[28] An antiphospholipid screen should include anti B2GP1 antibodies with lupus anticoagulant and anticardiolipin antibodies as per the Sapporo International consensus statement on an update of the classification criteria for definite antiphospholipid syndrome (APS)[29]

The investigations most likely to give useful information are:

1. postmortem
2. placental histology
3. fetal chromosomal analysis
4. antiphospholipid antibodies

However, investigations must be individualised, as the above will not be required for all women. Before offering any investigations, a history should be taken to appreciate the clinical presentation to guide investigations. Under-investigation impedes efforts at gaining an accurate diagnosis however unfocussed investigation could yield results which were not contributory to the loss, thus clinicians should consider the clinico-pathological correlation between abnormal investigation results and the clinical condition.

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

Thrombophilia screening should be performed selectively, once the placental pathology report is received. To determine which women require a thrombophilia screen at their postnatal follow up appointment, see Placental Pathology Tool, developed by the International Rainbow Clinic Network, 2025. See Follow Up Visit and Placental Pathology Tool V1.0 (April 2025)

Offer the following investigations to all parents if the cause is unknown:

Kleihauer to identify feto-maternal haemorrhage

This should be offered to all women as early as possible after presentation, irrespective of Rhesus status. This is especially relevant if there is vaginal bleeding or other sensitizing event.

As a Kleihauer is not routinely performed for Rhesus positive women, the clinical reason should be clearly documented on the request. The request may need to be discussed with laboratory staff to minimise the chance of sample rejection in a Rhesus positive mother. If there is a large feto-maternal haemorrhage, repeat the Kleihauer after birth if the woman is Rhesus negative and the fetal Rhesus status is positive or unknown, to guide anti D dosing.

Fetal infection screen

- Maternal viral serology for toxoplasma, rubella, cytomegalovirus
- Syphilis serology if not screened at booking
- Parvovirus B19 (especially if hydrops)
- Obtain a swab from the baby's axilla
- Placental swabs: see appendix 3

    - You may need two people for the procedure
    - Lay the placenta on a clean surface on the maternal surface
    - Choose an area of about 3x3cm away from the umbilical cord insertion
    - Clean this with an alcohol wipe
    - Lift up the amnion with a pair of sterile forceps. The amnion should be thin and semi-transparent
    - Incise the amnion with a sterile scalpel
    - Once incised the amnion will peel away from the chorion to expose a tented gap on the fetal surface
    - Swab in this gap between the amnion and chorion with a sterile swab.

Postmortem

It is recommended that all perinatal postmortems should be performed by pathologists with expertise in perinatal pathology. Within Greater Manchester this is the perinatal histopathology service at Royal Manchester Children's Hospital. Within Cheshire and Merseyside, the perinatal histopathology service is at Alder Hey Children's Hospital.

Postmortem should be offered to all parents who experience a second trimester loss where the cause is unknown, though the information obtained may be more limited at early gestations[30]. Postmortem can be full, when all organs are examined, or limited to specific locations e.g. head, chest or abdomen. There is also the option of an external postmortem. Offer the parents the opportunity to discuss their options. Written consent should be obtained from an appropriately trained individual. To support parents to make an informed

decision regarding postmortem examination, patient information can be found at https://www.sands.org.uk/post-mortem-examination-0. Please also see appendix 2.

If a postmortem is accepted by the family, send the signed written consent form and a completed perinatal hospital postmortem referral form (maternal details, history, reason for PM). See appendix 4 for consent forms and help sheet.

Placental pathology

This should be offered from 14 weeks gestation, as per the Royal College of Pathologists Tissue pathway for histopathological examination of the placenta, even if postmortem examination is declined[31]. There may be local variation on the national guidance. If the clinician feels that placental pathology is indicated at 13-13+6 weeks, please discuss with the local perinatal histopathologist before sending.

In Greater Manchester, histopathological examination of the placenta should be carried out by the perinatal histopathology service at Royal Manchester Children's Hospital. For Cheshire and Merseyside, placental histopathology is performed at Alder Hey Children's Hospital.

Swabs and cord samples (if appropriate) should be taken prior to placing the placenta in formalin or other preservative (in accordance with local policy) with the excess drained off prior to transport. If the placenta cannot be fixed in formalin, it should be refrigerated and sent to the laboratory at the earliest opportunity. Report all infectious agents to the pathologist (for example coronavirus, hepatitis, HIV). The appropriate placental pathology request form should be completed and sent with the placenta as per local policy.

Where nothing specific is identified on placental histology the negative finding is always useful. The placenta may, however, show an unexpected positive finding that may have implications especially in cases such as recurrent pregnancy loss as part of an undiagnosed autoimmune spectrum. Chronic histiocytic intervillositis (CHI) is a rare, inflammatory condition of the intervillous spaces, characterised by extensive maternal infiltration of inflammatory cells and fibrin deposition. It is associated with pregnancy loss in all trimesters, fetal growth restriction and recurrent pregnancy loss, due to the high recurrence rate. It is a histological diagnosis, characterised by CD68 immunostaining[32], [33]. See section on Follow Up Visit for the details of the recommended medication regime in a subsequent pregnancy. Further advice may be sought from the Rainbow Clinics at MFT or Liverpool Women's Recurrent Miscarriage clinic.

Selective Investigation (only offer if there is a clinical indication):

If 16+0 weeks and above

- External examination of the baby should be offered
- A detailed external assessment should be possible from 16 weeks
- See page 14-15 of the ICP

If the mother has fever, flu-like symptoms, abnormal liquor (purulent or offensive) or prolonged ruptured membranes

- FBC, CRP, lactate
- Maternal blood cultures
- MSSU
- HVS
- Endocervical swabs
- Throat / nasal swabs (coronavirus, influenza)

Fetal genomic testing

- Offer fetal genomic testing in line with the national genomic test directory rare and inherited disease eligibility criteria [34] (with the exception of an isolated neural tube defect). Criteria for genetic testing in the context of second trimester pregnancy loss are:

- R22 common aneuploidy screening (by QF-PCR) and microarray. Fetus with a likely chromosomal abnormality, which should be used in cases of isolated miscarriage with additional features suggestive of chromosome abnormality.

- R318 recurrent miscarriage with products of conception available for testing – defined as three or more miscarriages.

- Place 2-3cm of umbilical cord in a 20ml leak-proof, dry, sterile, plastic container, or sterile saline if stored overnight (not formalin). The container should be carefully labelled, wrapped with absorbent material and placed in a sealable polythene sample bag. If the sample sent is not obviously fetal particularly for earlier gestations then the laboratory will require a maternal blood sample in an EDTA bottle to be sent with the tissue sample.

- Do not send cord samples routinely or if prenatal testing by chorionic villus sampling (CVS) or amniocentesis has been performed and a result obtained. Do not send for fetal sexing. See appendix 5 for full referral criteria. If in doubt contact the cytogenetics service. For Greater Manchester St Mary's Hospital 0161 276 6553. For Cheshire and Merseyside Liverpool Women's Hospital 0151 702 4229.

If there is no identifiable or obtainable umbilical cord

- Take 2cm^3 of placenta and send in saline to genomics as soon as practically possible, even if proceeding to postmortem or clinical genetic examination.

If fetal anomaly or dysmorphic features

Genetic examination of the baby should be offered (with the exception of isolated neural tube defects such as spina bifida or anencephaly which are unlikely to have a genetic cause). This should be discussed with clinical genetics. For Greater Manchester this is St Mary's Hospital 0161 276 6506. For Cheshire and Merseyside, this is Liverpool Women's Hospital 0151 702 4228/4229. The postmortem consent form should be used to obtain consent for this examination. The baby should be transferred to the mortuary who will arrange transfer to the appropriate hospital for the clinical genetic examination.

If history suggests maternal substance abuse

- Maternal urine for cocaine metabolites

If hydrops fetalis is present

- Red cell antibody screen
- Maternal anti-Ro (SSA) and anti-LA (SSB) antibodies (also test for these if PM shows endomyocardial fibroelastosis or AV node calcification)

If fetal intracranial haemorrhage (on postmortem examination)

- Maternal alloimmune anti-platelet antibodies.
- Blood samples are required from mother and father.

If there is no obvious cause

- Thyroid function tests
- HbA1C

If clinical suspicion or the mother is symptomatic

- Maternal herpes simplex serology

NB further investigations may be required 12 weeks postnatally / at the follow up appointment – see 5.19 Follow Up Visit.

5.17 Further Management of Baby Including Transfer and Funeral Arrangements

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

Transfer of baby to the mortuary

Allow parents the time they wish to spend with their baby before transferring the baby to the mortuary. Prior to transfer, ensure two name bands are completed with three identifiers. State “baby of (mother’s name), mother’s NHS number, date and time of giving birth as well as the hospital the baby was born at”. Attach one name band to the baby.

Follow local policy regarding transfer to the mortuary. Arrange transfer and if parents wish to accompany their baby, notify the Anatomical Pathology Technician (APT) first and other relevant staff e.g. bereavement midwife, mortuary staff, security. A member of maternity staff must accompany the family. If the parents are not accompanying the baby, once they have said their goodbyes, the baby should be placed in an infant body bag by staff, ensuring that all body parts including the face are covered. The second name band should be attached or inserted into the transport window of the infant body bag. If any personal items, such as a teddy bear, or any jewellery items are to accompany the baby, then these should be labelled with baby’s identification bands.

Taking baby home

Occasionally the family may wish to take their baby home. There is no legal reason why they cannot take their baby home or directly to the funeral directors of choice, unless the death has been referred to the medical examiner or coroner. This would be extremely rarely the case in second trimester miscarriage but in this case, the release of the baby would need to be approved by the respective person. The parents should be informed that the appearance of the baby may deteriorate rapidly and this may affect the quality of information obtained at postmortem if the baby is taken home before the postmortem. The alternative is for the parents to take the baby home after the postmortem. The parents’ wishes should be supported. The baby must be taken home in an appropriate casket or Moses basket. The transport home must be appropriate i.e. private not public transport. The mortuary must be informed if the parents are taking their baby home. Local policy should be followed and relevant paperwork completed. It may be possible for the parents to loan a cuddle cot from the maternity unit for use whilst the baby is at their home.

Some hospices may offer the use of a bereavement suite (previously known as cold room facilities) (see appendix 7). This allows the family to stay with the baby and say goodbye in a supportive environment if this is not possible in the maternity unit. See Support for you and your baby - North West Neonatal Operational Delivery Network

Whilst there is no legal requirement to bury or cremate babies who are born without signs of life before 24 weeks’ gestation, many families will wish to. Parents should be given details of the options available, which may depend on gestation and the contract held with the funeral director and the crematorium. Complete a Non Viable Fetus form which authorises

cremation or burial and send it to the dedicated individual in your trust i.e. mortuary or bereavement centre. Options may include hospital cremation, private burial or private cremation. Some hospitals offer both individual cremation and shared cremation. In a shared cremation, several babies are cremated at the same time. If a hospital cremation is chosen, ask the parents what they wish to do with the ashes. If they wish to collect them advise when and where this will occur. If they do not, or if the Trust policy is to scatter ashes in a designated place e.g. baby garden, ask the parents if they wish to know when this will occur. At very early gestations, or if the hospital offers shared cremation only then the parents should be informed that there will not be any individual ashes to collect.

If the parents would like the hospital to help with the funeral arrangements, refer to local hospital policy. Document the parents' wishes and agreed arrangements.

There is also an option of home burial for babies born without signs of life under 24 weeks gestation. This is not an option for babies born with signs of life who subsequently die (this requires a registration of birth and neonatal death and referral to the coroner in the first instance).

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

After discharge

After the parents have returned to home, they can arrange to return to hospital to see their baby if they wish. Follow local policy to advise the parents who they should contact to make arrangements (bereavement office, bereavement midwife, mortuary).

5.18 Other Postnatal Considerations

Some Trusts hold an annual multi-faith Remembrance Service, which parents should be informed about. Individual maternity units may also run their own support initiatives e.g. Honeysuckle Team at Liverpool Women's NHS Foundation Trust - https://www.uhliverpool.nhs.uk/services/service-finder/maternity/honeysuckle-bereavement-service. See page 35 for a full list of relevant regional and national support organisations.

Antenatal screening results

There should be a robust method of communication with the screening midwife. First and second trimester screening results should still be communicated to the mother in the event of pregnancy loss. This must be done sensitively, for example by letter expressing condolences. See appendix 8 for a template letter.

Follow up

Discuss with the mother when and where the postnatal follow-up should take place. An appointment with the appropriate consultant obstetrician or gynaecologist should be offered, maintaining continuity where possible. Explain to the parents that it may take 12 weeks or more to receive investigation results and the postmortem report. If the parents do not wish to return to see the consultant, it is good practice to send a letter to the family and the mother's GP.

5.19 Follow Up Visit

Follow up of parents after a pregnancy loss is a key element of care, with an opportunity to assess maternal recovery both physically and psychologically as well as to convey information about investigations performed and agree a management plan for future pregnancies if considered in the future.

Particular care should be taken with women with a history of psychiatric illness and the vulnerable groups of women, with a high standard of communication between all health professionals such as the psychiatrist, GP and health visitor.

Preparation is essential for any such consultation as parents who have experienced a pregnancy loss should not have the trauma of an unprepared consultation added onto that experience. It should be noted what the parents' wishes are for follow up appointments.

If the parents have given the baby a name, health care professionals should use the baby's name in discussions with the family.

Prior to Consultation

1. Ensure all results are available
2. Ensure any local case reviews are available
3. Ensure the PMRT report is available (22+0 weeks and over)

At Consultation

1. Enquire about psychological wellbeing
2. Results of investigations
3. Consider whether further investigations are required:
   - Refer to the Placental Pathology Decision Tool which states:
   - Full thrombophilia screen if placental histopathology shows maternal vascular malperfusion (MVM) / villitis of unknown (a)etiology (VUE) / fetal vascular malperfusion (FVM)
   - Anti-cardiolipin antibodies, lupus anticoagulant, anti-beta2-glycoprotein-1 antibodies if placental histopathology shows chronic histiocytic intervillositis or massive perivillous fibrin deposition.
   - Maternal anti-Ro/La (SSA/SSB) antibodies if hydrops fetalis and postmortem shows endomyocardial fibroelastosis/AV node calcification
   - Maternal alloimmune anti-platelet antibodies (blood samples are required from mother and father) if fetal intracranial haemorrhage is demonstrated on postmortem examination
   - Anticardiolipin antibodies, lupus anticoagulant and anti-beta2-glycoprotein-1 (anti-B2GP1) antibodies if fetus morphologically normal and cause unknown
4. Cause of second trimester miscarriage if known
5. Pre-pregnancy plan for next pregnancy
   a) Smoking status
   b) Alcohol intake and illicit drug use
   c) Folic acid advice
   d) BMI optimisation
   e) Any psychological issues
   f) Medication review
   g) Pre-pregnancy medical conditions
   h) Care plan for next pregnancy
   i) Book under Consultant Obstetrician
   j) Consider whether aspirin or LMWH are indicated
   k) Consider referral to preterm labour clinic for cervical length scans +/- progesterone pessaries or cervical suture depending on presentation and likely cause of pregnancy loss. For future pregnancies, consider history-indicated insertion of cervical cerclage and if recurrent second trimester pregnancy loss consider transabdominal cerclage (TAC)
   l) Consider referral to recurrent miscarriage clinic
   m) Consider referral to Rainbow Clinic (see local criteria)
   n) Offer extra ultrasound scans for reassurance
   o) If CHI on placental histology discuss with Rainbow Clinic at Saint Mary's Oxford Road Campus or Saint Mary's at Wythenshawe, MFT or Liverpool Women's Recurrent Miscarriage clinic for commencement of aspirin, LMWH, prednisolone and hydroxychloroquine at 7 weeks gestation after an early viability scan, followed by close ultrasound surveillance.
   p) Women with a second trimester miscarriage due to a placental cause should be offered serial growth scans 4 weekly from 32 weeks as per the moderate risk category for fetal growth restriction in SBLV3.2 (April 2025)[35]. Women in the Rainbow clinic will also have a uterine artery Doppler at 20-23 weeks.
   q) Personalised plan for birth.
   r) Consider extra precautions for postnatal depression

Following a second trimester pregnancy loss, inform parents of the following:

- Approximately a 7 - 8% risk of recurrent second trimester pregnancy loss[36].
- Approximately a 25 - 35% risk of preterm birth

The consultant should write a letter to the parents summarising the discussion and plan as above and send a copy to their GP.

5.20 Feedback from Families

Maternity units should work with their Maternity and Neonatal Voices Partnership to gather parent feedback and ensure parents are involved in service development. Feedback may highlight good practice and positive patient experience as well as identifying areas for improvement in maternity bereavement services. See appendix 9 for an example parent bereavement questionnaire.

5.21 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 https://www.childdeathhelpline.org.uk/

CRADLE

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

Website www.cradlecharity.org

Cruse Bereavement Care

For adults and children who are grieving.

Helpline 0808 808 1677

Website www.cruse.org.uk/get-support/

Daddies with Angels

Advice and support to male family members following the loss of a child/children.

Website www.daddyswithangels.org/

Jewish Bereavement Counselling Service

Supporting Jewish individuals through loss and bereavement

Helpline 020 8951 3881

Email enquiries@jbcs.org.uk

Website https://jbcs.org.uk/

Lullaby Trust

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

Helpline 0808 802 6868

Website www.lullabytrust.org.uk/bereavement-support/

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/about-baby-loss/

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 www.sands.org.uk/about-sands

Twins Trust

Bereavement and special needs support groups

Email enquiries@twinstrust.org

Website twinstrust.org/bereavement.html

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 www.tommys.org/

Children of Jannah

Support for bereaved Muslim families in the UK, based in Manchester.

Helpline 0161 480 5156

Email: info@childrenofjannah.com

Website www.childrenofjannah.com

Lighthouse Therapy Service

Post Infant Loss Support Service covering Merseyside

Website lighthouses-therapy-services.com

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 listening-ear.co.uk/butterflies/

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 onceuponasmile.org.uk/

SPACE

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

Website www.thereisspaceforyouhere.com/

Liverpool Bereavement Services

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

Website liverpoolbereavement.com/

Love Jasmine

Supports families 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.

Call/Text 07566 225 253

Website www.lovejasmine.org.uk/

Finding Rainbows

child and baby loss support based in Ashton, Tameside

Website https://findingrainbows.org/

6. Monitoring / Audit

This guideline has been peer reviewed by the Regional Guidelines Group. It will be updated every 3 years.

7. Details of other relevant or associated documents

For stillbirth (from 24+0 weeks) please refer to the **North West Management of 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 neonatal death, please use the **North West Management of Neonatal Death** Guideline and ICP version 1, April 2025.

8. Definitions / glossary

9. Consultation with Stakeholders

Wide consultation across all maternity and neonatal units in the North West and respective MNVPs.

10. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

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

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Second Trimester Pregnancy Loss, version 4
Directorate and service area:	Maternity Services
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Elaine Church, Consultant Obstetrician
Contact details:	

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Staff caring for women experiencing second trimester pregnancy loss
2. Policy Objectives	To guide and standardize care
3. Policy Intended Outcomes	To guide and standardize care
4. How will you measure each outcome?	
5. Who is intended to benefit from the policy?	Families experiencing second trimester pregnancy loss
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: *Yes* • Patients/ visitors: *Yes* • Local groups/ system partners: *Yes* • External organisations: *Yes* • Other: *No*
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** See table above

Information Category	Detailed Information
6c. What was the outcome of the consultation?	Comments received considered and incorporated
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.
Where a negative impact is identified without rationale, the key groups will need to be consulted again.

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

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

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.	
Name of person confirming result of initial impact assessment:	Elaine Church

Appendices

Appendix 1 - Patient information

miscarriageassociation.org.uk/information/miscarriage

sands.org.uk/bereavement support book

rcog.org.uk/patient information/when your baby dies before birth

twinstrust.org/navigating grief booklet

Guidance on miscarriage and stillbirth for Jewish Parents

Appendix 2 - Deciding about a postmortem examination: Information for Parents and Professionals

https://www.sands.org.uk/post-mortem-examination-0

https://www.hta.gov.uk/guidance-professionals/guidance-sector/post-mortem/consent-post-mortem-sector/post-mortem-model

sands.org.uk/Understanding Why Your Baby Died (March_2023)

Cheshire and Mersey local information:

https://www.uhliverpool.nhs.uk/application/files/7317/5378/7505/Post_Mortem_Examination.pdf

Appendix 3 - Placental Pathology

Greater Manchester and Eastern Cheshire

MFT Placental histology information sheet

Request Form for Histopathological Examination of Placenta

Lancashire, South Cumbria, Cheshire and Merseyside

- Saint Helens and Knowsley Cytology request form
- Alder Hey Request Form for Histopathological Examination of the Placenta (this may also be completed online via Digicare)

Placental swabs

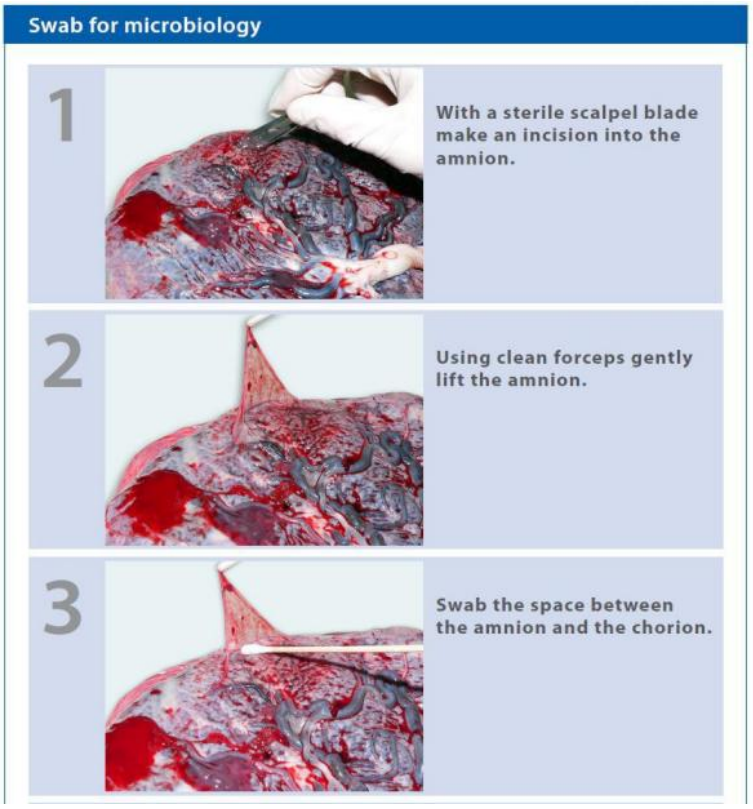


Image courtesy of South Australian Perinatal Practice Guideline: Histopathology Management of the Placenta sahealth.sa.gov.au/Histopathology Management of the Placenta PPG v2

Placental Pathology Decision Tool

Clinical Placental Pathology Decision Tool

Appendix 4 - Postmortem Consent Form, Request Form

Greater Manchester and Eastern Cheshire

- MFT Postmortem consent form
- MFT Postmortem help sheet for consent form
- Requesting a postmortem examination

Lancashire, South Cumbria, Cheshire and Merseyside

- https://www.nth.nhs.uk/resources/a-simple-guide-to-post-mortem-examination/
- Alder Hey Postmortem consent form

Appendix 5 – Genomic Testing

North West NHS Genomic Laboratory Hub

Test Request Forms - Manchester University NHS Foundation Trust
Use Genomic testing form (Rare Disease)

Appendix 6 - Butterfly Project

neonatalbutterflyproject.org

Appendix 7 - Information on Hospices in the Northwest

1. Francis House Children's Hospice – *Didsbury, Manchester*
   Offers Rainbow Rooms, which are specially cooled bereavement suites where a child can remain at the hospice after death until the funeral, with family-friendly adjoining lounge space. Families can personalise the room and receive ongoing bereavement support. Francis House Children's Hospice

2. Derian House Children's Hospice – *Chorley, Lancashire*
   Has Sunflower Rooms, dedicated bereavement rooms where a child can stay after death as an alternative to a funeral home and families can spend private time saying goodbye. Family accommodation and support continues as needed.
   derianhouse.co.uk

3. Claire House Children's Hospice – *Wirral / Liverpool*
   Provides Butterfly Suites (private comfortable rooms) that allow families to stay together after a child's death. Practical and emotional support including bereavement counselling and follow-up support is also offered. https://www.clairehouse.org.uk/find-support/get-support/contact-us/

4. Brian House Children's Hospice (Butterfly Suite) - *Blackpool & Fylde Coast*:
   Offers its own Butterfly Suite where families can take time to say goodbye after a child's death (even if not previously known to the hospice). Brian House Children's Hospice

5. Little Lights Baby Hospice (previously Zoe's Place) – *Liverpool*:
   Offers specialist care and compassionate support for families following the death of a child, whether or not they received end-of-life care at the hospice. The dedicated Snowdrop Suite provides a calm, private space where families can spend cherished time with their baby in the days after their passing. https://www.lzp.org.uk/services

Appendix 8 - Miscarriage Screening Results Letter

Patient letter - Miscarriage Screening

Appendix 9 - Collecting feedback from families

Below is an example of one that can be used:

Example letter to parent

Patient Bereavement Questionnaire

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