GUIDELINES FOR THE MANAGEMENT OF STILLBIRTHS AND NEONATAL DEATHS

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<th>Policy</th>
<th>Procedure</th>
<th>Protocol</th>
<th>Guideline</th>
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GUIDELINES FOR THE MANAGEMENT OF STILLBIRTHS AND NEONATAL DEATHS

1. Introduction

Overall the theme should be one of sensitive communication.

1.1 • Bad news needs to be broken in a sensitive way
• Provide psychological support for woman and partner
• Provide continuous care - ensure continuity of carer
• Expect a variety of emotions - anger/aggression/silence

1.2 Ensure good communication between care givers. Obstetrician, Midwife, Paediatrician and Parents. Inform Bereavement Counsellors.

• Provide adequate information and explanations
• Frequent repetition may be necessary
• Allow mothers choice - with guidance where necessary

1.3 Allow time for decisions to be made - may want to go home - readmitted the following day.

• Information must be given with explanation - what is happening, what to expect
• Allow time for discussion
• Allow time to answer questions
• Discuss programme of care and pain relief

Some parents may be afraid of the baby’s appearance.

Some may require information regarding funerals.

Encourage parents and close family members to see and hold their baby. Suggest they may like to wash and dress him/her using their own clothes if available.

Always refer to the baby by name - write the name on cot card and in notes.

Allow parents time and privacy with their baby - they should not be rushed.

Label the baby with I.D. bands, both parents names if not married, sex, date and time of birth - place mothers ID bands in back of notes.

When parents are ready carefully weight the baby and take footprints and handprints. Where possible take a lock of hair.
Offer to contact relevant Minster of religion.

Take photographs of the baby - as soon after birth as is practically possible. Contact Bounty and/or medical illustration. If parents have their own camera encourage them to take their own photographs.

When parents are ready the baby should be transferred in the moses basket to the appropriate place with midwife and porter. Mortuary book must be completed correctly including information of ID bands of the baby - surname of both parents (if not married), Christian names, sex of baby, date and time of birth.

2. Definitions

I  **NON-VIABLE FETUS** - less than 24 weeks gestation and where there is no evidence of life at delivery

II **STILL BIRTH** - more than 24 weeks gestation and where there is no evidence of life at delivery

III **NEONATAL DEATH** - death after livebirth whatever duration of pregnancy

3. Management

When a pregnant woman is admitted after 20 weeks and pre-term delivery appears likely she should be admitted to the central delivery suite and not the gynaecology ward. The midwife in charge should involve the obstetric and paediatric staff at an early stage.

In particular the paediatricians can give patients clear information of:

- chances of survival
- likelihood of significant handicap
- plan at delivery with regard to resuscitation
- reasons for not resuscitating very pre-term babies

Survival rate by gestation and birthweight to 1 year.

<table>
<thead>
<tr>
<th>Gestation (wks)</th>
<th>Survival</th>
<th>Weight</th>
<th>Survival</th>
</tr>
</thead>
</table>

AER/ES/PAJD – Stillbirths and neonatal deaths
Dec 2008
Review Dec 2011
Data from 1998 CESDI Survey

The pregnant woman should be cared for on delivery suite with access to analgesia, midwifery and obstetric care and if necessary fetal monitoring.

On admission an assessment of gestational age and therefore of viability should be made with an appropriate plan. Pregnancies beyond 24 weeks should be monitored with either continuous CTG or intermittent auscultation. Where the pregnancy is less than 24 weeks CTG monitoring should NOT be undertaken but an attempt to hear the fetal heart with a CTG monitor or see at an ultrasound scan should be made.

4. Investigations

Prior to any specimens being taken, verbal consent must be obtained and full explanation given. All fetuses referred to the fetal malformations units for examination should be accompanied by a consent form (see attached guidelines for transfer etc)

Fetal Investigations

<table>
<thead>
<tr>
<th>SPECIMEN</th>
<th>CONTAINER</th>
<th>REQUEST</th>
<th>SENT</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cord blood</td>
<td>Plain red virology</td>
<td>TORCH and virology</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parvovirus/B19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Biopsy</td>
<td>Medical Genetics in universal container in saline gauze</td>
<td>Chromosomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cord blood</td>
<td>EDTA</td>
<td>Blood group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cord blood</td>
<td>EDTA</td>
<td>Hb and Electrophoresis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cord blood</td>
<td>Heparin (green) Medical genetics</td>
<td>Chromosomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whole baby</td>
<td>Photographs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Foot and hand prints</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whole baby</td>
<td>Wrapped in saline gauze (if pre viable)</td>
<td>Fetal Pathology Department, UHW Dr Vujanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Swabs (if infection suspected) | Charcoal swabs ear, eyes, nose | C&S

N.B. Whole body x-rays of babies should not be carried out on babies prior to transfer to UHW for postmortem.

### Maternal Investigations

<table>
<thead>
<tr>
<th>SPECIMEN</th>
<th>CONTAINER</th>
<th>REQUEST</th>
<th>SENT</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal blood</td>
<td>EDTA (Purple)</td>
<td>Hb A1C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal blood</td>
<td>Plain red virology</td>
<td>TORCH and Parvovirus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal blood</td>
<td>EDTA (Purple) x 3</td>
<td>Kleihauer FBC LFTs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal blood</td>
<td>Blood Sodium Citrate</td>
<td>KCCT, Anticardiolipin, Lupus anticoagulant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal blood</td>
<td>Fluoride/Oxalate</td>
<td>Blood sugar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Culture swabs (HVS and blood cultures)</td>
<td>Standard swabs</td>
<td>Culture and sensitivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Urine</td>
<td>Plain bottle</td>
<td>Toxicology screen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal blood</td>
<td>Green (heparinised)</td>
<td>Chromosomes</td>
<td></td>
<td></td>
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</table>

### Placental

<table>
<thead>
<tr>
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<th>CONTAINER</th>
<th>REQUEST</th>
<th>SENT</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete placenta</td>
<td>No preservative</td>
<td>Fetal Pathology Department, UHW Dr Vujanic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placental biopsy</td>
<td>Universal contained</td>
<td>TORCH Listeria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membrane</td>
<td>Universal container Medical Genetics wrapped in saline gauze</td>
<td>Chromosomes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Placental swabs | Charcoal swabs | C&S

* If clinically indicated

N.B. Samples for Medical Genetics should not be frozen and should be kept at 4°C. The sample should not be put in fixative. The sample should be thick enough to include dermis.

5a. Disposal of fetal tissue after post mortem examination (fetuses less than 24 weeks, showing no signs of life)

All fetal tissue not processed into paraffin blocks is returned to the body. No organs are retained without parental consent. Parents have two options for disposal. The fetus can be returned to the referring unit and burial arranged by the parents or they may wish the University Hospital of Wales to arrange disposal. In this instance, all fetal material is sent to the incinerator used by the hospital. Each fetus has its own container and a service is held in the mortuary chapel beforehand. Fetuses are not cremated individually.

5b Disposal of baby after post mortem (after stillbirth or neonatal death)

All babies over 24 weeks have to be buried or cremated. Parents may wish to organise their own funeral or the hospital can arrange a funeral using the contracted funeral directors. The burials are at Thornhill or Western Cemetery, Ely. Cremations are at Thornhill. The midwife in charge will arrange for the parents to see the appropriate person to organise the funeral (at Llandough this would be the Bereavement Counsellors on extension 6808).
Written Documentation

STILLBIRTH

The Stillbirth Certificate must be signed by the Doctor or the Midwife. Please ensure that they sign the Certificate, print their name in block capitals and in the Midwife’s case include their PIN number.

Doctor must complete the Death Certificate. All questions must be answered. Ensure that writing is legible. Age to be recorded in days, hours or minutes as appropriate.

Post Mortem Required?

NO

Baby to be transferred to Mortuary prior to funeral. Complete Mortuary Admissions Book in accordance with Mortuary Policy.

If parents wish to take the baby home, the contracted Funeral Director will transfer the baby.

Telephone : 20514627

YES

Obtain written consent from parents. Photocopy mothers notes and PM Form and send to the Mortuary with the Baby Notes (if applicable) and the baby.

Phone the Funeral Director (Tel 20514627) to transfer the Baby and notes to the UHW Mortuary. Telephone the Mortuary Attendant (Tel 20744269) to expect arrival (Llandough only).

INVNND.DOC/AER/JLS/
MANAGEMENT OF INTRA-UTERINE DEATH / FETAL ANOMALY

Use in conjunction with guidelines for the management of stillbirth, neonatal death and second trimester intra-uterine death.

Feticide is a prerequisite prior to induction in case of termination for fetal anomaly at gestation more than 21+6 weeks.

- Confirm IUD on ultrasound. This may not be available until the following day.
- Must be confirmed by SpR/Consultant with skills in diagnosis of IUD. Some clinicians may prefer to ask a second clinician to confirm the diagnosis.
- Careful, sensitive explanation and a flexible approach are necessary
- Services of bereavement counsellor must be made available
- Discuss care with appropriate consultant
- There is seldom place for caesarean section

When the woman is clinically unwell, i.e. in association with an abruption, she should be stabilised/resuscitated and delivered by the safest means after discussion with the on-call consultant.

Where the woman is well and wishes to go home her wishes should be respected and appropriate follow-up arranged.

The dosage of misoprostol is dependant on the gestation, as the uterus becomes more sensitive to prostaglandin with increasing gestation.

The incidence of uterine rupture in women with previous caesarean section during Induction of Labour with misoprostol is between 3.5%-4.4% compared to unscarred uterus. Hence extra vigilance and regular monitoring is required in women with previous caesarean section

Liberal analgesia provided as per woman’s wishes including PCA/Epidural.

Vaginal misoprostol is inserted in the posterior fornix and the woman is asked to remain supine for up to 1 hour after the insertion of misoprostol. Misoprostol can be self-administered by the woman to maintain privacy. However midwife/doctor can administer the misoprostol in women who are not happy to self-administer.
Management of the woman who has had an IUD should be as per following regimen:

**Gestation ≤ 24 weeks:**

Oral mifepristone 200mg followed by misoprostol 36-48hrs later.

First dose of misoprostol is **800ugm** vaginally
Followed 3 hours later by **400ugm** of misoprostol vaginally, and this dose is repeated 3 hourly for a maximum of 4 doses.

If uterine evacuation does not occur with the above, the dosage of misoprostol can be repeated after an interval of 12 hours from the last dose of misoprostol.

**Women with previous caesarean section can be given the above regimen after discussion with the consultant on-call**

**Gestation between 24-34 weeks:**

Oral mifepristone 200mg followed by misoprostol 36-48hrs later.

**200ugm** of Misoprostol is given vaginally every 3 hourly for a maximum of 5 doses.

The regimen can be repeated after 12 hours if there is failure of delivery.

Women with previous caesarean section can be given the above regimen after discussion with consultant on-call.

**Gestation >34 weeks:**

Bishop score > 7: ARM and oxytocin.

Bishop score < 7: 200mg of oral mifepristone followed by misoprostol 36=48hours later.

**100ugm** of misoprostol is given vaginally every 3 hourly for a maximum of 5 doses. (200umg tablets can be snapped in half)
The above regimen can be used in women with previous caesarean section after discussion with consultant on-call.

References


PROTOCOLS FOR CYTOGENETIC INVESTIGATIONS

1. **Couples with a history of recurrent pregnancy loss**
   When **more than** 2 pregnancies have been lost (regardless of successful pregnancies) - 5 mls blood in lithium heparin from each partner.

2. **Stillbirths**
   Only a very limited service is available. Investigations can be performed where the fetus has malformations, other than isolated neural tube defects, or a chromosome abnormality has been detected pre-natally. Please give full clinical details.

   If the fetus appears fresh or shows signs of slight maceration.
   1. Cardiac stab for blood or cord blood in lithium heparin, plus
   2. A small biopsy of skin (or other solid tissue) in **saline**.

   If the fetus appears significantly macerated
   1. A biopsy of fetal membranes (amnion) wrapped in **saline**.

   Solid tissue biopsies, including fetal membrane, must be placed into **TRANSPORT MEDIUM** as soon as possible. Please ensure sterile control.

   The sample should be sent to the laboratory immediately if practicable, by carrier service. At night, weekends, Bank Holidays, the sample may be kept in a refrigerator at +4º C until it can be sent to the laboratory.

   **NB**: Cytogenetic investigations can only be performed on live cells, therefore:

   **A. THE SAMPLE MUST NOT BE PUT INTO FORMALIN OR ANY OTHER FIXATIVE**

   **THE SAMPLE MUST NOT BE FROZEN**

   **B. Skin biopsies must be thick enough to include the dermis.**

3. **Products of Conception**
   We are currently unable to perform routine cytogenetic investigations on products of conception.
FOR ANY ENQUIRIES PLEASE CONTACT THE LABORATORY ON THE
FOLLOWING NUMBERS:    74 - 4020    Dr Michael Creasey
                         74 - 4024    Mr Selwyn Roberts
Guidelines for the management of Late Spontaneous miscarriage (up to 24 weeks)

<table>
<thead>
<tr>
<th>Author</th>
<th>Responsible</th>
<th>Lead of Group</th>
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<tbody>
<tr>
<td>Alex Rees, Elizabeth Stephenson, Pina Amin</td>
<td>Labour Ward Forum</td>
<td>Pina Amin</td>
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<tr>
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<td>Obs &amp; Gynae</td>
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OUT OF DATE POLICY DOCUMENTS MUST NOT BE RELIED ON
GUIDELINES FOR MANAGEMENT OF LATE SPONTANEOUS MISCARRIAGE (UP TO 24 WEEKS)

Introduction
Please refer to the introduction within the guidelines on the management of stillbirths and neonatal deaths and remember the theme again is one of sensitive communication.

Definition
I NON VIABLE FETUS - less than 24 weeks gestation and where there is no evidence of life at delivery
II STILL BIRTH - more than 24 weeks gestation and where there is no evidence of life at delivery
III NEONATAL DEATH - death after livebirth whatever duration of pregnancy

Management

All women admitted in threatened preterm labour beyond 20 weeks should be admitted to the central delivery suite or antenatal ward for initial assessment. For women with pregnancies of uncertain gestational age the decision should be taken by the midwife or registrar. Any women who is less than 20 weeks should usually be admitted to the gynaecology ward.

When the initial assessment has been carried out by the midwife and senior SHO the registrar should be informed and must review the patient if delivery looks likely. In this event the registrar should also contact the on call paediatrician who should counsel the patient with regard to likelihood of survival and plan of care at delivery including plans with regard to resuscitation of the newborn infant. Where the gestation is very early (22-28 weeks) the paediatrician should be of registrar grade.

See guidelines for management of very pre-term labour.

Survival rates by gestation and birthweight to 1 year

<table>
<thead>
<tr>
<th>Gestation (wks)</th>
<th>Survival</th>
<th>Weight</th>
<th>Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>22-23</td>
<td>1%</td>
<td>&lt;500g</td>
<td>1%</td>
</tr>
<tr>
<td>24-25</td>
<td>20%</td>
<td>500 - 749g</td>
<td>20%</td>
</tr>
<tr>
<td>26-27</td>
<td>65%</td>
<td>750 - 999g</td>
<td>55%</td>
</tr>
</tbody>
</table>
Handicap rates for survivors at each gestational age\(^2\)

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<thead>
<tr>
<th></th>
<th>Major Handicap</th>
<th>Normal outcome or minor handicap</th>
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<tbody>
<tr>
<td>23 weeks</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>24 weeks</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>25 weeks</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>26 weeks</td>
<td>25%</td>
<td>75%</td>
</tr>
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Where there is fetal death:
The following investigations should be considered and fully discussed with the parents.

Maternal

<table>
<thead>
<tr>
<th>SPECIMEN</th>
<th>CONTAINER</th>
<th>REQUEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>Plain red virology</td>
<td>TORCH &amp; Parovovirus</td>
</tr>
<tr>
<td>Blood</td>
<td>Sodium Citrate bottle</td>
<td>KCCT Cardiolipin antibodies</td>
</tr>
<tr>
<td>Swabs</td>
<td>HVS Cervical swab</td>
<td>C &amp; S</td>
</tr>
<tr>
<td>Blood cultures (if pyrexial)</td>
<td>Cervical swab</td>
<td>C &amp; S</td>
</tr>
<tr>
<td>especially where Listeria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>suspected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal and paternal chromosomes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fetal

Documented verbal consent must be obtained prior to specimens being obtained.
Post mortem consent forms need to be signed by the parents.

<table>
<thead>
<tr>
<th>SPECIMEN</th>
<th>CONTAINER</th>
<th>REQUEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swabs (if infection suspected)</td>
<td>Charcoal swab, eye, ear, nose</td>
<td>C &amp; S</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Listeria</td>
</tr>
<tr>
<td>Skin biopsy (only if fresh specimen)</td>
<td>To Medical Genetics in universal container</td>
<td>Chromosomes</td>
</tr>
<tr>
<td></td>
<td>wrapped in saline gauze</td>
<td></td>
</tr>
<tr>
<td>Fetus (if investigation requested) see next page</td>
<td>Wrapped in saline gauze</td>
<td>Pathology Department UHW</td>
</tr>
</tbody>
</table>
Placental

<table>
<thead>
<tr>
<th>SPECIMEN</th>
<th>CONTAINER</th>
<th>REQUEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete placenta</td>
<td>Large pot</td>
<td>Pathology with fetus, as above</td>
</tr>
<tr>
<td>Placental biopsy</td>
<td>Universal container → Virology</td>
<td>TORCH Listeria</td>
</tr>
<tr>
<td>Placental swabs</td>
<td>Charcoal swab - maternal and fetal surface of placenta</td>
<td>Bacteriology</td>
</tr>
</tbody>
</table>

**Disposal of fetal tissue - Non Viable Fetus (up to 24 weeks)**

**Where the fetus is for investigation**


**DISPOSAL**

- After investigations, disposal in incinerator at UHW following blessing by hospital Chaplin.

**FUNERAL**

- Letter signed by Doctor who has seen baby. Arrangements made by Bereavement Counsellor next working day.

**Where the fetus is not for investigation**

**DISPOSAL**

- Fetus double wrapped & stored in allocated fridge in theatre. Blessing by hospital Chaplin before incineration at Sully.

**FUNERAL**

- Baby in own clothes, I.D. bands. Transfer to mortuary in Moses basket. Letter signed by Doctor who has seen baby. To be seen by Bereavement Counsellor.

**References**

1. CESDI Annual Report 1997
2. J Rennie Archives of Disease in Childhood 1996; 74: p 214-218