Late Miscarriage, MTOP and Early Neonatal Death from 20+0 to 23+6 weeks gestation.

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1.0 Introduction

In the UK, it is estimated that 1 in 4 pregnancies end in loss during pregnancy or birth.

For the purpose of this guideline, the types of loss included are defined as:

- Late Miscarriage (missed or spontaneous)
- Medical Termination of Pregnancy (MTOP) for fetal abnormalities
- Early Neonatal Death (live birth ending in death)

A late miscarriage is one which occurs between 13+0 and 23+6 weeks gestation (1). Late miscarriages are not very common; they happen in 1-2% of pregnancies. Women who experience a late miscarriage from 20+0 weeks gestation will receive care in Maternity Services.

1.1 Definitions

Pregnancy losses up to 23+6 are called **Late Miscarriage** rather than a stillbirth due to the birth occurring before the legal age of viability. This distinction can be upsetting for some women because they give birth to their baby and, understandably, feel that it should be called a stillbirth, explanations should be given compassionately and terminology should be adapted to meet the emotional needs of the mother.

A **Spontaneous Late Miscarriage** is defined when women experience symptoms of abdominal pain and/or vaginal bleeding and recognisable signs of labour, with the process resulting in the unexpected birth of the baby. See section 4.12 onwards for guidance on providing care during birth and the postnatal period for women who experience a spontaneous miscarriage.

"**Live Birth** *refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born*." (9)

When signs of life are recognised at birth, at ANY gestation (including babies born as the result of MTOP), the subsequent death, must be managed as an **Early Neonatal Death** (A neonatal death is defined as a baby born showing signs of life, at ANY gestation during pregnancy, which dies within 28 days of being born); care should be adapted appropriately and all documentation should be completed in line with local guidance and legal requirements.

A **Missed Miscarriage** is one where the baby has died or not developed in utero, but labour does not commence spontaneously. In many cases, women are asymptomatic, with no indication of a problem with the pregnancy, until the fetal demise is identified by a health

professional when attempting to auscultate the fetal heart or perform an ultrasound scan. In these instances, labour may be managed expectantly or may be induced.

2.0 Objective

The purpose of this guideline is to support obstetric and maternity staff to deliver gold standard care for women experiencing a second trimester pregnancy/neonatal loss, from 20+0 to 23+6 weeks gestation or neonatal death.

3.0 Scope

This guideline applies to all medical and midwifery staff working in Maternity Services.

The guideline should be used to guide the care of women with late miscarriage (Missed or Spontaneous), medical termination of pregnancy for fetal abnormalities or early neonatal death from 20+0 to 23+6 weeks gestation in conjunction with the care of Late Miscarriage/MTOP/Early Neonatal Death Care Pathway.

A separate guideline is available to support the care of women experiencing pregnancy loss after 24 weeks gestation:

- **Clinical guideline for the Stillbirth, Medical Termination of Pregnancy (MTOP) or Neonatal Death from 24+0 weeks gestation**

Standard Operating Procedures (SOP) are available to support this guideline:

- **SOP for the care, storage and transfer of a fetus or stillborn baby (Use of the Baby Refrigeration Cabinet and CuddleCot™)** Care Storage And Transfer Of A Fetus Or Stillborn Baby • **SOP for supporting parents who wish to take their stillborn baby home**

4.0 Main body of the document

4.1 Care of Bereaved Parents

The Ockenden report (2022) highlights that healthcare professionals must be deliver "Compassionate, individualised, high quality bereavement care for all families who have experienced a perinatal loss" (2)

In the event of any miscarriage of pregnancy, the news can come as a complete shock to the parents; they deserve to be cared for with empathy and compassion. Commenting about mid trimester loss a Sands report claims:

> "No level of care can take away the pain and grief families feel, but high-quality care can have a huge impact on their wellbeing, help them to process their grief and begin to learn to live without their much-loved baby, in the short-term and for the rest of their lives." (3)

Healthcare professionals should be aware of what the hospital can offer and allow time for parents to make decisions and decide what is right for them. Parents should be offered choices and support around bereavement care, including time and privacy with their baby, opportunities to make memories and discussion around post mortem and funeral options. The individual needs of the woman and (where appropriate) her partner should be central to the

provision of care and any communication with them. Health care professionals should actively listen and take the lead from the woman and her partner regarding preferred terminology. It is important that healthcare professionals are sensitive to the responses and needs of parents from different cultural backgrounds and religious groups. However, it is vital that healthcare professionals do not make assumptions concerning culture, and approach each parent as an individual needing support at an extremely difficult time.

The preferences of bereaved families should be sought and all bereaved parents must be offered informed choices about decisions relating to their care and the care of their babies. A parent-led bereavement care plan should be in place, providing continuity between settings and into any subsequent pregnancies. The National Bereavement Care Pathway (NBCP) for Miscarriage provides a dedicated, evidence-based care pathway with guidance for professionals delivering bereavement care to parents and families (7)NBCP Miscarriage July 2022.pdf (nbcpathway.org.uk)

4.2 Diagnosis of Late Miscarriage & Immediate Care

A thorough clinical history and physical examination are important in the assessment of women presenting with symptoms or signs suggestive of any type of late miscarriage.

Care should be provided in line with the guideline for Admission to the maternity assessment unit v2.pdf (trent.nhs.uk)

When fetal demise is suspected but the woman is not actively miscarrying, auscultation and cardiotocography must not be used for confirmation, it must be confirmed by two-dimensional ultrasound at the earliest opportunity by an experienced and suitably trained clinician (a sonographer or an Obstetrician). It is advisable to obtain a second opinion from a suitably trained person whenever possible although it is recognised that this may not always be possible in emergency situations. If the diagnosis is suspected in the community setting then the woman should be referred to hospital for confirmation.

Following the diagnosis and confirmation of a miscarriage the parents must be given time to absorb and accept this news. A clear, sensitive and honest explanation should be given as to what has happened by experienced staff. The language used should be clear. Below is an example statement:

"I'm terribly sorry, I can see your baby's heart clearly and it is not beating, I'm sorry, this means your baby has died."

If the woman has attended on her own, unless it is an emergency, it may be prudent to delay detailed explanation until support has arrived. An immediate offer to contact her partner or a family member or friend should be made, and support given.

Parents should be offered the use of the bereavement suite throughout the admission. For the purpose of clinical care and during labour/birth it may be necessary to transfer the patient to a room with appropriate facilities on the Birthing Centre. The partner/family may remain with the mother as long as she wishes.

Although care should be taken not to overload the parents with too much detail initially, it is important to give adequate information. The trust Information for Parents Following Bereavement; Leaflet 1, should be offered: "When Your Baby Dies, - Preparing for birth, meeting your baby & creating memories". **See Appendix 1.**

Parents should be included in discussions about options and their wishes should be considered. Some mothers will want to go home and see family members before delivery whilst others will want the induction process to commence as soon as possible.
The possibility of passive movements should be discussed with the woman experiencing any type of late pregnancy loss. Following the diagnosis of a late missed miscarriage, it should be explained that she may still feel the baby move inside the uterus as it floats around in the amniotic fluid; mistaking this sensation for the feelings of active physical movements of the baby can be very distressing for the mother if she is not prepared for it.

In the case of a threatened miscarriage or MTOP (without feticide) when a mother continues to experience fetal movements it should be explained, compassionately, that some babies may survive birth and show signs of life. Guidance for assessing signs of life, and appropriate discussions/documentation can be found in section 4.12 of this guideline.

Staff should use a Maternity Bereavement Pack to guide care from the point a pregnancy loss is diagnosed, or when MTOP care is commenced. The pack includes all relevant documentation and checklists required to provide care for bereaved families.

See **Appendix 8** for the checklist for Late Miscarriage/MTOP) and **Appendix 9** for the checklist for Neonatal Deaths.

The woman should be given a 24-hour contact number if she goes home.

4.3 Late pregnancy loss / Neonatal Death in Multiple Pregnancy

Clinicians should be aware that intrauterine fetal death occurs more frequently in multiple pregnancies than singleton pregnancies. According to the MBRRACE-UK Perinatal Mortality Surveillance Report for Births 2019, women expecting twins were 2.2 times more likely to experience stillbirth than women expecting singletons (4)

Clinicians should appreciate the complexity and mixed emotions of couples who experience miscarriage, termination or selective reduction of one fetus with a surviving twin. They will require the same support through delivery and bereavement care. Parents may wish 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; this should be discussed and offered.

The timing and mode of delivery for multiple pregnancies in the case of single fetal demise will depend on chorionicity, gestation, the position of the fetuses and the wellbeing of the surviving baby/babies. Specialist advice should be sought in complex cases from the local multiple pregnancy lead.

4.4 Clinical Investigation of the Cause of Miscarriage

After diagnosis of miscarriage, clinical assessment and laboratory tests should be recommended to assess maternal wellbeing and to determine the possible cause of fetal

death, the chance of recurrence and possible means of avoiding future pregnancy complications.

See **Appendix 2**, for a table of recommended tests and investigations at the point of diagnosis of a miscarriage.

4.5 Threatened Labour at Extreme Premature Gestation – Signs of life

4.5a Birth at the Threshold of Viability

In the event that a mother is likely to give birth at the threshold of viability, caregivers should refer to the British Association of Perinatal Medicine (BAPM) Framework for Practice for The Perinatal care of Extreme Preterm Birth before 27 weeks of gestation, (BAPM, 2019). The framework states that a key ethical consideration for decisions about instituting life sustaining treatment for an extremely preterm baby is the baby's prognosis – the risk of an acceptable (or unacceptable) outcome if active (survival focused) care is undertaken. If there is a plan to provide life-sustaining treatment for the baby, then it follows that the pregnancy and birth should be managed with the aim of optimising the baby's condition at birth and subsequently (5).
BAPM advise a stepwise approach to decision-making, involving three key stages:

1. Assessment of the risk for the baby if delivery occurs, incorporating both gestational age and factors affecting fetal and/or maternal health.
2. Counselling parents, and their involvement in decision-making.
3. Agreeing and communicating a care plan

If a mother may deliver her baby at a very early gestation, the obstetric history and antenatal course must be considered carefully with particular attention to ultrasound scan(s) to accurately calculate gestation/estimated fetal weight and to identify other risk factors.

Whenever possible, parents should be involved in planning an extremely preterm birth. The planning consultation should include senior clinical staff from the obstetric, midwifery and neonatal teams who will be caring for the mother and her baby before, during and after the birth.

Spontaneous birth before 24 weeks' gestation is often a very distressing time for parents and they are likely to be unsure what to expect. When time allows before birth, a midwife or obstetrician should counsel parents clearly about potential signs of life and have a conversation about the intended plan of care taking into consideration parents' wishes for end of life care. Even where there is little time for in depth discussion prior to birth, a sensitive and compassionate brief explanation of the key points below may help to avoid misunderstanding.

Key points for discussion with parents

- Babies born before 24 weeks of gestation are small and their lungs and other organs are not developed enough for them to live after they are born. Often, they do not survive the birth process.
- Some babies who have died a few minutes before birth may show some brief reflex movements after birth. However, these do not constitute 'signs of life'. In such a case baby's birth and death are not registered.

- Some babies may survive birth and show signs of life such as an easily visible heartbeat, breathing or sustained gasps, or definite movement of their limbs. The length of time a baby will shows these signs is hard to predict and may be only a few minutes but can occasionally be up to a few hours. If this is the case a doctor will be asked to attend to confirm signs of life and comfort care will be provided

4.5b Gestation-based Risk Assessment and Care Planning

Accurate information about the current pregnancy, including assessment of both fetal and maternal health should be used to refine gestation-based risk of absolute survival and survival without severe impairment.

Risk assessment should be performed with the aim of stratifying the risk of a poor outcome into three groups: extremely high risk, high risk, and moderate risk (5). See **Box 1** overleaf

There is no objective way of defining a risk as 'extremely high' versus 'high' and families differ in the outcome that they regard as unacceptably poor. Thus, risk assessment may need to be modified in the light of the parents' knowledge, views and values. It is important that parents are offered choices and supported to make decisions appropriate for their individual preferences.

Consistency in obstetric and neonatal care is essential, either to ensure that the baby is born in the best possible condition or to avoid unnecessary intervention. The agreed plan should be clearly documented and communicated to all members of the obstetric and neonatal teams who may be involved in care of the family.

Uncertain gestation

If the gestation is uncertain, or where there is parental request for resuscitation, the opportunity to discuss care with the neonatal team should be offered. A plan of care should be agreed and documented including the implications of signs of life being seen and any decision to attempt resuscitation. This would not automatically mean that the baby is resuscitated; the final decision lies with the neonatologist present at delivery after careful assessment of the baby. Resuscitation may be appropriate if baby is born vigorous and of an apparently good birth weight.

Less than 22+0 weeks

Where gestational age is certain and is below 22+0 weeks, it would be considered in the best interests of the baby, and standard practice, not to offer neonatal intensive care. If it is possible that the birth may be delayed to a point where active care of the baby would be planned, transfer of the mother to a maternity unit adjacent to a neonatal intensive care unit should be considered. Parents should be counselled by the obstetric team that it is not appropriate to attempt to resuscitate babies born before 22+0 weeks gestation. Parents should be informed that their baby may attempt to gasp and move when born. In these circumstances; the baby should be kept comfortable and treated with respect, dignity and love.

22+0 weeks to 22+6 weeks

If the gestational age is certain and 22+0 to 22+6 weeks; the baby is considered extremely high risk with a >90% chance of either dying or surviving with severe impairment if active care is instigated. For babies with an extremely high risk of death or of survival with unacceptably

severe impairment despite treatment, palliative (comfort-focused) care would be in the best interests of the baby and life-sustaining treatment should not be offered. There is no absolute indication for neonatologist attendance at the birth although for individual families this may be helpful. The obstetric team should discuss this with the parents and document the discussion.

The parents should be informed that their baby may attempt to gasp and move when born. In these circumstances; the baby should be kept comfortable and treated with respect, dignity and love. If, after discussion, the parents do want their baby to be resuscitated, neonatal stabilisation may be considered following assessment of risk and multi-professional discussion with parents.

23+0 weeks to 23+6 weeks

If gestational age is certain at 23+0 to 23+6 weeks (with favourable risk factors) the baby is considered high risk. These babies have a 50-90% chance of dying or surviving with severe impairment if active care is instigated. If a baby at this gestation has unfavourable risk factors, including severe fetal growth restriction, it would fall into the extremely high-risk category with a >90% chance of either dying or surviving with severe impairment if active care is instigated. For babies with a >50% risk of death or of surviving with unacceptably severe impairment despite treatment, it is uncertain whether active (survival focused) care is in the best interests of the baby and their family. Parents should be counselled carefully and parental wishes should inform a joint decision to provide either active or palliative treatment. Ideally, a senior neonatal clinician who has previously met the parents will be available to attend the birth and supervise implementation of the agreed plan.

The assessed category of risk to the baby (including the inherent uncertainty around this) should be conveyed sympathetically and with clarity, and the hopes and expectations of parents explored with honesty and compassion in a realistic way. Clear, balanced information should be shared and care options discussed. Time should be allowed for clarification and questions, and parents offered the opportunity to revisit discussions with the perinatal team at any point, acknowledging the challenging nature of the information that they are being asked to receive and the decisions that are being made.

If the fetal heart is heard during labour, a professional experienced in neonatal resuscitation should be available to attend the birth. A decision not to start resuscitation may be appropriate and in the best interests of the baby, particularly if the parents have expressed this wish following antenatal counselling. However, if following counselling by the neonatal registrar/consultant, the parents wish their baby to be resuscitated (or where there is no time for discussion with the parents), the neonatal team should be present at delivery.

Following consultation with parents, initial care of the birth will follow one of two pathways: “active (survival focused)” or “palliative (comfort focused)” (5). See **Figure 2** overleaf)

4.6 Perinatal care of extreme preterm birth before 27weeks of gestation (BAPM 2019)

Perinatal management of extreme preterm birth before 27 weeks of gestation
A BAPM Framework for Practice

BOX 1

Extremely high risk: The Working Group considered that babies with a > 90% chance of either dying or surviving with severe impairment if active care is instigated would fit into this category. For example, this would include:

- babies at 22^{+0} - 22^{+6} weeks of gestation with unfavourable risk factors
- some babies at 23^{+0} - 23^{+6} weeks of gestation with unfavourable risk factors, including severe fetal growth restriction
- (rarely) babies ≥ 24^{+0} weeks of gestation with significant unfavourable risk factors, including severe fetal growth restriction

High risk: The Working Group considered that babies with a 50-90% chance of either dying or surviving with severe impairment if active care is instituted would fit into this category. For example, this would include:

- babies at 22^{+0} - 23^{+6} weeks of gestation with favourable risk factors
- some babies ≥ 24^{+0} weeks of gestation with unfavourable risk factors and/or co-morbidities

Moderate risk: The Working Group considered that babies with a < 50% chance of either dying or surviving with severe impairment if active care is instituted would fit into this category. For example, this would include:

- most babies ≥ 24^{+0} weeks of gestation
- some babies at 23^{+0} – 23^{+6} weeks of gestation with favourable risk factors.

Box 1 represents the consensus of the Working Group in regard to risk categories for the purposes of this framework.

4.7 Medical termination of pregnancy (MTOP) for fetal abnormality

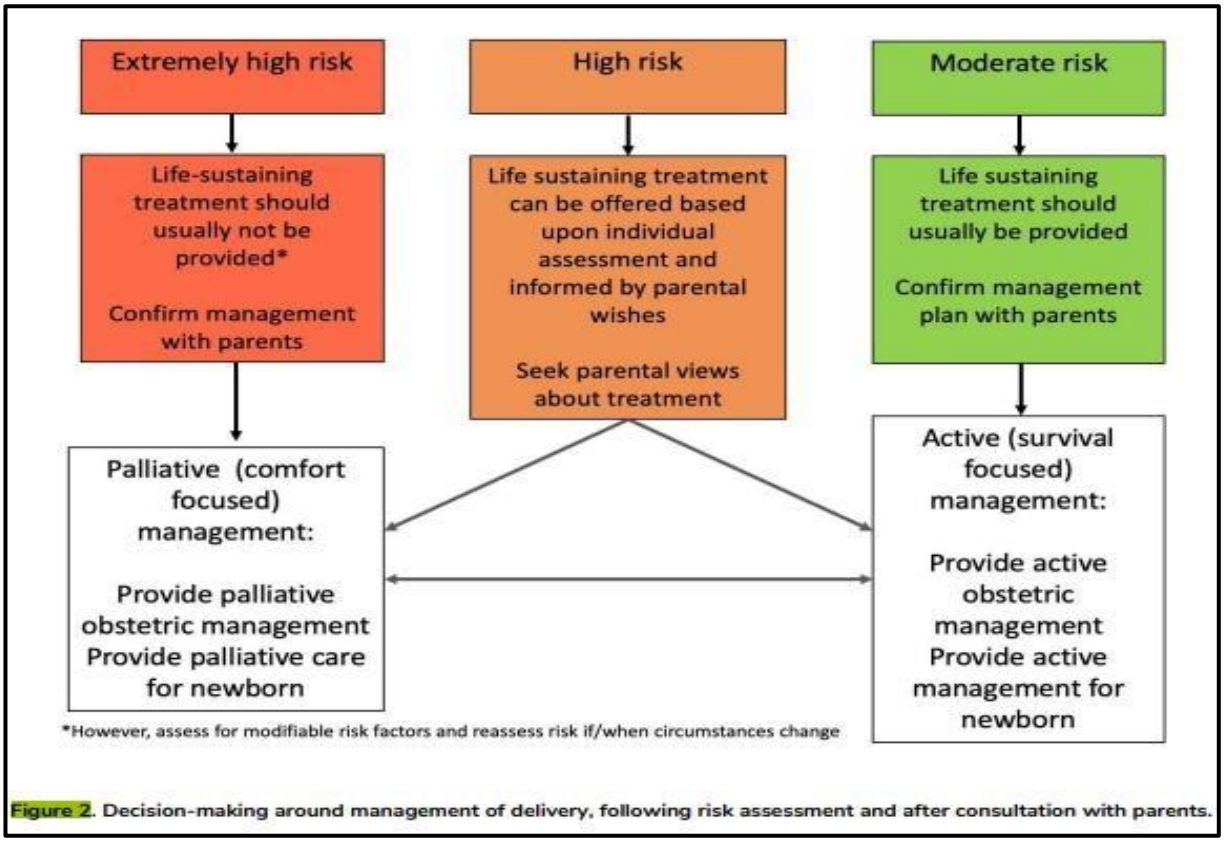

Figure 2. Decision-making around management of delivery, following risk assessment and after consultation with parents.

Termination of pregnancy is legal at any gestation following a diagnosis of a severe abnormality. Parents should be cared for with the same compassion as with an unexpected fetal loss.

The RCOG recommends that "for all terminations at gestational age of more than 21+6 weeks, the method chosen should ensure that the fetus is born dead" (3). MTOP at this late gestation requires a feticide procedure, prior to induction of labour. Women are referred to a local tertiary Centre for feticide to be performed, they then return to the local unit for induction after the procedure has been performed. Clause E of the Abortion Act form (HSA4) will need to be completed by two doctors prior to performing this procedure.

The feticide procedure is performed under ultrasound control with 15% KCl solution injected into either the umbilical cord vein or heart. A further ultrasound scan is performed 30 minutes after the procedure to ensure fetal demise.

In certain specific situations where the fetus would die in the immediate neonatal period from the abnormality e.g. anencephaly, limb body wall complex, bilateral renal agenesis and lethal skeletal dysplasia's, feticide is not a legal requirement (3).

The timing of medication for induction will need to be agreed with the fetal medicine unit. Mifepristone 200mg can be given prior to or after the procedure, then the woman would usually return to her local unit for induction with misoprostol 48 hours after mifepristone. In general mifepristone 200mg could be given 48 hours prior to the procedure, however, if there is a high risk that labour will follow administration of mifepristone, e.g. if there is spontaneous rupture of the membranes, polyhydramnios or the pregnancy is near term (>34 weeks) then this should be given after the feticide.

Parents should be informed that at gestations below 21+6 weeks, the baby may be born with signs of life (See section 4.12 for definitions of signs of life). The baby should be wrapped and treated with respect and dignity. The parents should be given the opportunity to hold their baby if they wish. Any baby born with signs of life who subsequently dies must be referred to the coroner and registered as a live birth and neonatal death irrespective of gestation.

Ensure the woman has a 24-hour contact number, for the relevant ward or clinical area, in case she starts to labour prior to her planned admission. The parents should be provided with the ARC (Antenatal Results and Choices) information booklet ARC-Ending-aPregnancy-After-Prenatal-Diagnosis.pdf (arc-uk.org)

See **Appendix 2** for a table of recommended tests and investigations to be performed at the onset of the MTOP process.

4.7a Induction of labour for Medical Termination of Pregnancy (MTOP)

Guidance for the process of induction of labour in cases of MTOP involves Pre-induction and induction treatment as detailed above for the care of late miscarriage. See **Appendix 4** for MTOP induction of labour drug regime.

4.8 Labour & Birth - Missed Miscarriage or MTOP
Vaginal birth is the recommended mode of delivery for most women with a late missed miscarriage or MTOP.

In the case of a missed miscarriage; women should be offered a choice of induction of labour or expectant care. The decision regarding mode of delivery in such complex cases should be made in consultation with a Consultant Obstetrician. Parents should be included in discussions and given informed choice regarding care. Informed consent should be obtained and documented in line with trust guidance prior to commencing the induction process.

In certain clinical situations the maternal medical condition may necessitate expediting the delivery; for example, if there is sepsis, abruption/antepartum haemorrhage (APH) and/or ruptured membranes. The method of delivery and/or induction of labour should be customised to the presenting condition and other patient factors including past obstetric/medical history.

Many parents are surprised that they will have to go through labour; shocked that there may be a delay in giving birth; and anxious that the delay may possibly mean there is an option to go home whilst awaiting the birth of their baby who has died. It is vital that they are fully informed.

Women experiencing a late miscarriage or MTOP will be deemed as high risk; the most appropriate place for care during labour and birth is likely to be the Birthing Centre under the care of Midwives and the Obstetric team.

Risk assessment should be completed in the Late Miscarriage/MTOP care pathway with consideration given to underlying medical or obstetric conditions and the potential risk of sepsis. Care during labour and birth should be documented in detail in the fetal loss care pathway/partogram.

4.9 Expectant care of Late Missed Miscarriage (20+0 to 23+6 weeks gestation) Women with a confirmed missed miscarriage, who are not in active labour and have no evidence of sepsis, pre-eclampsia, placental abruption/antepartum haemorrhage or membrane rupture, may choose expectant care

Well women with intact membranes and no laboratory evidence of disseminated intravascular coagulopathy (DIC) should be advised that they are unlikely to come to physical harm if they delay labour for a short period.

Women contemplating prolonged expectant care should be advised that the value of post-mortem may be reduced, and that the appearance of the baby may deteriorate. There is a 10% chance of maternal DIC within four weeks from the date of fetal death and an increasing chance thereafter (6). It should be noted that it is not usually possible to determine the exact date of the death. Women who delay labour for periods longer than 48 hours should be advised to have testing for DIC twice weekly.

Women who are managed as an outpatient should be given a 24-hour contact number for any time between diagnosis and delivery.

See **Appendix 3,** for the table of tests required for women choosing expectant care.

4.10 Active care of Late Missed Miscarriage/MTOP

- In about 90% of cases, vaginal birth can be achieved within 24 hours of induction of labour for women with missed miscarriage. Vaginal birth carries the potential advantages of immediate recovery and quicker return home.
- A combination of Mifepristone and Misoprostol should usually be recommended as the first-line intervention for induction of labour. Women with a favourable cervix, in early labour, or with ruptured membranes may be offered amniotomy followed by oxytocin infusion.
- Urgent delivery is required if there is sepsis, abruption/antepartum haemorrhage (APH), or severe pre-eclampsia.
- In the case of previous caesarean section, a discussion of the safety and benefits of induction of labour should be undertaken by a consultant obstetrician, and the dosage and administration of Misoprostol should be discussed.

4.10a Stage One - Pre-Induction of Labour (For all women regardless of previous caesarean section/uterine scarring)

- Between 20+0- and 23+6-weeks' gestation, regardless of whether there is a uterine scar, a single dose of 200mg oral mifepristone should be given for pre-induction of labour.
    - Mifepristone is a steroidal drug, taken orally, which sensitises the uterine wall to prostaglandin-induced contractions and ripens the cervix. ○ Mifepristone is a recorded drug, its administration should be recorded in the controlled drug book
    - Mifepristone should only be administered within the maternity unit and the woman should be observed when taking this medication
- The woman should remain in the unit for one hour following administration to ensure she is not affected by nausea or vomiting (if the woman vomits within 60 minutes, the treatment will need to be repeated).
- If the woman has an unscarred uterus and remains well, she should be given the option to go home and return for stage two of treatment between 36-48 hours later
- The woman should be given a date and time to return to the Birthing Centre and a 24-hour contact number for any time between diagnosis and delivery

- The woman should be advised to contact the Birthing centre if she experiences any of the following symptoms: ○ Pyrexia ○ Tachycardia ○ Vaginal bleeding ○ Abdominal pain/contractions ○ Spontaneous rupture of membranes
    - Any other symptoms of deteriorating health

See **Appendix 4** for stage one of treatment: Active care of labour - drug regime information.

4.10b Stage Two – Induction of Labour

- During readmission for labour care, the Trust Information for Parents Following Bereavement; Leaflet 2, should be offered: "When Your Baby Dies: Birth Registration, Funeral Arrangements & Options for post mortem examination". **See Appendix 1**

- On return to the unit the women should have a full set of observations completed and a MOEWS score calculated. Other tests/samples should be obtained as detailed in **Appendix 2**
- Misoprostol is a synthetic prostaglandin which acts as a uterine stimulant; it should be administered to induce labour. Dosage will depend on the gestation at which the miscarriage occurred (see **appendix 4**)
- Misoprostol is not yet licensed in the UK, for use in the induction of labour, however it is recommended by the RCOG, and endorsed by NICE as the most effective drug for this purpose in women with and IUFD. Barnsley Hospital operates a policy on the use of unlicensed drugs; the policy states that the prescriber of an unlicensed drug must inform the patient of the practice and obtain their consent prior to administration. Patients should be provided with the misprrostol leaflet and the consent form should be completed in advance of treatment
- Women experiencing regular contractions should NOT be given Misoprostol. They should be reviewed after 2 hours, and a decision made regarding the best option for augmentation of labour
- Vaginal assessment should be performed prior to commencing oral or vaginal misoprostol (the vaginal route is preferred due to the lower incidence of side effects, but should be avoided if there is bleeding or signs of infection)
- 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, and if the clinician wishes to avoid the use of vaginal misoprostol, intravenous oxytocin may be considered after discussion with a Consultant Obstetrician
- The risk of uterine rupture with misoprostol, although small, is increased in women with a second trimester fetal loss and one or more previous Caesarean sections or other uterine scars.
- For women with **previous caesarean section (or other uterine scars)** the recommended doses of misoprostol should be used with caution; discussion with the parents about the safety and benefits of induction of labour should be undertaken by a Consultant Obstetrician.
- If delivery of the fetus is not achieved after the maximum dose of misoprostol, further treatment should be discussed with the Consultant Obstetrician and a repeat course of misoprostol considered after a 12-hour interval.

See **Appendix 4** for Stage two – Induction of Miscarriage; drug regime information.

4.11 Care in Labour

- Women should be admitted to the bereavement suite with access also to an appropriate delivery room to ensure that their emotional and practical needs can be met without compromising safety.
- Care in labour should be provided by an experienced midwife and the woman's' birth choices should be supported as for any labouring woman

- Obstetric staff should be vigilant to clinical features that may suggest uterine scar dehiscence/rupture: tachycardia, atypical pain, vaginal bleeding, haematuria and maternal collapse.
- The 'Care pathway for Pregnancy and Neonatal Loss after 20 Weeks Gestation' should be completed in all cases of Late miscarriage/MTOP
- The partogram within the care pathway should be completed in all cases of late missed miscarriage/MTOP so that clinical trends and complications may be identified promptly
- Adequate analgesia should be provided, and all modalities should be made available including regional analgesia
- Women with fetal demise and Group B Streptococcal (GBS) colonisation do not require antibiotic prophylaxis in labour
- In the case of a spontaneous miscarriage, when a decision is made for palliative (comfort focused) care of the baby at birth, only interventions for maternal benefit are appropriate. Intrapartum fetal heart rate monitoring is not advised, although assessing or listening for the presence of a fetal heart to check viability may be helpful in clarifying expectations around the baby's condition at birth and be preferable for parents.

4.12 Assessment for signs of life

Even at extreme premature gestations some babies may be born displaying signs of life.

Health professionals should assess signs of life, for births included in the scope of this guidance. The assessment should be undertaken while ensuring that care following birth is respectful and that the individual needs of the baby, the woman and her partner are prioritised at this difficult time. The midwife or other attending health care professional may observe for visible signs of life while holding or wrapping the baby and handing them to the parents (if the parents wish to hold the baby). Subsequent observation for signs of life should be discreet and respectful. Assessment should be based on persistent, readily evident, visible signs. Listening for a heartbeat with a stethoscope or palpation of the umbilical cord is not necessary. Evident signs of life after birth would include one or more of the following:

- Easily visible heartbeat seen through the chest wall
- Visible pulsation of the cord after it has been clamped
- Breathing, crying or sustained gasps
- Definite movement of the arms and legs

Since fleeting reflex activity including transient gasps, brief visible pulsation of the chest wall or brief twitches or involuntary muscle movement can be observed in babies that have died shortly before birth it is recommend by MBRRACE-UK that such fleeting reflex activity observed only in the first minute after birth does not warrant classification as signs of life.

In situations where there are visible signs of life, a doctor (usually the attending obstetrician) should be called to confirm the presence of signs of life. The role of the doctor in this circumstance is not to provide active survival-focused care but to support the parents and to enable the doctor, after the baby's death, to complete a death certificate for the baby. This avoids the potential distress that can occur when the doctor cannot complete a death certificate because they have not seen the baby. It is preferable for the baby to be seen by a member of the obstetric team, rather than the neonatal team as calling a neonatologist may result in confusion for the family, and a perception that the decision to provide comfort care, rather than survival focused care, was inappropriate.

If it is not possible for a doctor to attend in time to witness signs of life, then following the baby's death, the doctor and the attending midwife or other health care professional should sensitively discuss and together decide if signs of life were present. This discussion should include the parents' observations if they wish to share them. It is important to recognise that there may be differing perspectives. See section 4.11 for legal requirements where signs of life are observed.

National clinical guidance for the determination of signs of life following spontaneous birth before 24+0 weeks of gestation where, following discussion with the parents, active survival focused care is not appropriate MBRRACE-UK is available at signs-of-life-guidance-v1.2.pdf (le.ac.uk) (5)

4.13 Care of Extremely Premature Birth with Signs of Life where Comfort focused (palliative) care is planned

Where there is an extremely high risk of a poor outcome for the baby, it would be considered in the best interests of the baby, and standard practice, not to offer active neonatal XXXXXXXX. On average, babies born before 24 weeks of gestation who receive comfort care in the delivery room live for approximately 60 minutes (range from a few minutes to several hours) (5).

The aim of palliative neonatal care is to support the parents and their baby and to avoid interventions that may cause discomfort, pain or separation of the baby from the parents. This care should be delivered in the most appropriate location for the family (which is not necessarily a neonatal unit) and should not necessitate in utero transfer. There should be an emphasis on family centred care, with opportunities for parents to create positive memories of their baby.

The baby should be treated with dignity and respect, and comfort care should be provided. Wrap the baby and offer the parents the option to hold the baby. If the family do not wish to see or hold the baby, it should be cared for appropriately referring to the SOP for the care, storage and transfer of a fetus or stillborn baby (Use of the Baby Refrigeration Cabinet and CuddleCot™). Care Storage and Transfer of a Fetus Or Stillborn Baby or the SOP for Supporting Parents who wish to take their stillborn baby home.

4.14 Management of the 3rd Stage of labour following Miscarriage/MTOP

The third stage of labour can be managed by continuing the Misoprostol regime (See appendix 4). Consideration may be given for the administration of oxytocin in line with local normal delivery guidance.

4.15 Postnatal Care of the Mother and the baby

- The individual needs of each family should be identified and accommodated. Assistance should be given to facilitate the grieving process including empathetic care, appropriate literature and contact telephone numbers
- Seeing and spending time with baby is valuable for parents. It may be necessary to prepare them about their baby's appearance. Some parents may wish to see and hold their baby

immediately after the birth, others may prefer to wait. Either way their decision should be respected and supported

- Parents should be offered the use of the cooling cot to maintain the condition of the baby. The cooling cot can improve the quality of bereavement care as it allows parents to spend more time with their baby and enhances their lasting memories. Refer to the SOP for the care, storage and transfer of a fetus or stillborn baby (Use of the Baby Refrigeration Cabinet and CuddleCot™). Care Storage and Transfer of a Fetus Or Stillborn Baby
- An external examination of the baby should be performed by the midwife and in cases of difficulty or suspected abnormality should be confirmed by a paediatrician
- **See Appendix 5** for details of the tests required to be performed on baby/placenta.
- The baby should be weighed ○ The birth weight should always be entered into the GROW database in order to generate a birth weight centile to identify if the baby was small for gestational age
- The baby should be labelled, details should include:
  ○ Baby's name ○ Date
  and time of birth ○
  Mothers FULL name
- Parents may be encouraged to choose clothes for their baby and supported to dress him/her
- Parents should be offered and supported with opportunities to create lasting memories with their baby and should be offered mementos to keep
- **See Appendix 6** for a full list of keepsakes and memory making options.
- Suppression of lactation should be discussed with the woman. Cabergoline 1mg may be administered orally, unless there is maternal hypertension/pre-eclampsia or puerperal Psychosis
- Thromboprophylaxis risk assessment should be performed as pregnancy loss increases the risk of venous thromboembolism

4.16 Supporting Parents who wish to take their baby home

- The family may wish to take their baby home. The parents' wishes should be supported
- The baby may deteriorate rapidly, parents should be prepared for this, and provided with appropriate care advice
- There is no legal reason why they cannot take their baby home or directly to the funeral directors of choice.
- 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.

Refer to the SOP for Supporting Parents who wish to take their stillborn baby home.

4.17 Clinical Investigations after a Miscarriage, MTOP or Neonatal death

There are several reasons why investigations into the cause of the miscarriage are important:

- Parents may find out the cause of death which can help with the grieving process
- Useful information may come to light which could be significant in planning future pregnancies
- For research purposes, to prevent pregnancy losses in future

Even with full investigation parents should be advised that a specific cause of death is often not found.

The three types of investigation most likely to give useful information are:

1 Post mortem

- There are two types of post-mortem examination available; full hospital exam or MRI scan (Please refer to the bereavement pack for more detailed information)
- Parents should always be given post-mortem patient information leaflets
- Parents should be given the opportunity to discuss their options
- Written consent must only be obtained by a trained individual (Doctor or Bereavement Midwife).

2 Placental histology

- Placental histology should be performed with verbal consent and is recommended even if post-mortem examination is declined

3 Fetal Chromosomal Analysis

- These tests are necessary to determine if the baby had an underlying genetic disorder
  - If parents wish for genetic testing to be performed, it is necessary to complete a 'Diagnostic Genetics Service' request form and the test required is 'Karyotyping'
- If parents decline genetic testing, they should only consent to a limited post mortem and exclude genetic testing on the consent form

Parents' wishes regarding clinical investigations after a stillbirth should be clearly documented within the narrative in the care pathway.

4.18 Birth and death certification and notification

Certification and notification procedures in the UK differ for babies born with signs of life (ending in a neonatal death) compared to a birth where there are no signs of life present.

Births where no signs of life are observed:

In the UK, a stillbirth certificate is only issued by the attending midwife or other health care professional for births at or after 24+0 weeks of gestation. For births up to 23+6 weeks, where no signs of life are observed, birth notification and birth and death certification are not required. Parents should be offered an unofficial 'certificate of birth' from the hospital to acknowledge their loss but this should not be insisted upon if the parents decline.

Births where signs of life are observed - at any gestation:

If a doctor has been present to witness signs of life before death occurs, that doctor must complete a neonatal death certificate and where appropriate **Part 1 of the Cremation 4 form** (available in the neonatal death bereavement pack).

If death occurs before a doctor has witnessed signs of life and (following discussions between the doctor and the attending midwife or other health care professional) it is agreed that there were persistent evident signs of life after birth, the doctor must inform the medical examiner's office/coroner to allow a neonatal death certificate to be issued.

For all live births ending in neonatal death, a member of the care team must complete a birth notification and the family must register the birth and death. In England the death must be reported to the local Child Death Overview Panel (CDOP). There is no statutory obligation to report all deaths to the Coroner, unless there is any concern that the death was unnatural.

In the case of a live birth which ends in neonatal death, disregard the (green) Late miscarriage task/documentation checklist *(Appendix 8) and refer to the (orange) neonatal death task/documentation checklist (Appendix 9).

4.19 Discharge of the mother after a Miscarriage, MTOP or neonatal Death

- The woman should be reviewed and deemed clinically well by a senior obstetrician prior to discharge
- The Trust Information for Parents Following Bereavement, Leaflet 3, should be offered: "When Your Baby Dies - Going home from hospital, ongoing support and preparing for the future" **See Appendix 1.**
- Arrangements should be in place to ensure follow up care. The woman should be offered support from her named community midwife and the bereavement midwife
- After discharge home, optimal communication with all professionals involved (and in particular the GP, health visitor and community midwife) is essential. The mother will continue to require postnatal care and should also receive information and advice about milk suppression or donation
- The woman should be given relevant contact details including the 24-hour number for the birth centre
- The woman should be given a discharge information pack with a handover of care and relevant information. For recommended contents of the discharge pack **see Appendix 7**
- Families should be made aware of funeral requirements and options. Staff can access information regarding funerals for babies born at less than 24 weeks gestation within the maternity bereavement pack **(Appendix 9)**
- All women and their partners should be offered bereavement support from the bereavement midwife. This can be provided from diagnosis of fetal demise/decision for MTOP, and through the postnatal period, with continuity of care into subsequent pregnancies
- When the mother goes home, she should be discharged from the Electronic Patient Record (EPR), even if she intends to return as an outpatient to continue to visit the baby in the bereavement suite
- If the baby is going to the mortuary it should be transferred together with the placenta and all relevant documentation. **Refer to the SOP for the Care, storage and transfer of a fetus or stillborn baby** Care Storage And Transfer Of A Fetus Or Stillborn Baby,
- If the baby is going home with the parents refer to the SOP for Supporting Parents who wish to take their stillborn baby home.
- A full task checklist and documentation checklist should be completed by midwives providing care and filed in the patient record. For task and documentation checklists **see Appendix 8**

5.0 Follow up consultation after Miscarriage, MTOP or Neonatal Death

- Follow up of patients who have had a miscarriage/baby death is a key element of care. It is an opportunity to assess maternal recovery from the event, both physically and psychologically; as well as to convey information about investigations performed.
- It is an opportunity to put in place a plan for future pregnancies if that may be considered in the future. Risk factors can be reviewed and addressed including the common risk factors for miscarriage as well as others that are apparent from the maternal history or investigations.
- Return to the Maternity Unit can be difficult and it is best done in another location. Inform parents in advance where the follow up consultation will occur.
- Preparation is essential for any such consultation. Patients who have been through the experience of having a miscarriage should not have the trauma of an unprepared consultation added to that experience. It should be noted what the wishes of the parents are for follow up appointments.

Prior to consultation ensure that:

- All results are available including placental histology and post-mortem if applicable
- Notes of any case review are available.
- The psychological well-being of both parents should be asked about and additional help offered if needed.

See **Appendix 9** for a list of recommended topics for discussion at the follow up consultation

5.1 Care in Subsequent Pregnancy following Miscarriage, MTOP or Early Neonatal Death

- A history of pregnancy loss should be clearly marked in the case record using the appropriate sticker on the front cover and detailed on the EPR
- Carers should ensure they read all the notes thoroughly before seeing the woman
- Women with a previous unexplained late pregnancy loss should be recommended to have obstetric antenatal care
- Carers of women with a previous miscarriage should be aware that maternal bonding can be adversely affected and should be vigilant for postpartum depression

6.0 Clinical Governance

Miscarriages of pregnancy from 22+0 weeks gestation are subject to review using the national standardised Perinatal Mortality Review Tool (PMRT). The aim of the PMRT is to support objective, robust and standardised review to provide answers for bereaved parents about why their baby died.

- The PMRT is completed by a multi-disciplinary team
- The parents' perspectives and any questions or concerns they may have regarding their care will be incorporated and addressed as part of the review PMRT parental engagement.pdf (trent.nhs.uk)
- Any care delivery issues identified through the PMRT are escalated through the Patient Safety Panel; where the case is discussed by an executive panel and a decision made as to whether it meets criteria for escalation to a Serious Incident Investigation
- The issues and actions from the investigation and the outcomes of the review will be shared with the parents at an appropriate and convenient time for the family
- Learning from PMRT cases will be disseminated to maternity staff via the Monthly Governance Newsletter

7.0 Roles and responsibilities

7.1 Midwives and Obstetricians

Midwives & obstetricians should work within the multidisciplinary team to provide the best evidence-based care for women in accordance with appropriate guidance from diagnosis to delivery.

8.0 Associated documents and references

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3. Sands, 2022 Sands.org.uk. 2022. [online] Available at: <https://www.sands.org.uk/sites/default/files/SANDS-BEREAVEMENT-CAREREPORT-FINAL.pdf> [Accessed 23 November 2021].
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5. British Association of Perinatal Medicine. 2021. *Perinatal management of Extreme Preterm Birth Before 27 weeks of Gestation (2019)*. [online] Available at: <https://www.bapm.org/resources/80-perinatal-Management-of-extreme-pretermbirth-before-27-weeks-of-gestation-2019> [Accessed 23 November 2021].
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8. Royal College of Obstetricians & Gynaecologists. 2021. *Late Intrauterine Fetal Death and Stillbirth (Green-top Guideline No. 55)*. [online] Available at: <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg55/> [Accessed 23 November 2021].
9. World Health Organization. International statistical classification of diseases and related health problems. Tenth Revision. Vol 2. Geneva, Switzerland: World Health Organization, 1993:129.

9.0 Training and resources

Training will be delivered as outlined in the Maternity Training Needs Analysis. This is updated on an annual basis.

10.0 Monitoring and audit

Any adverse incidents relating to the guideline for Late Miscarriage, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 20+0 to 23+6 weeks gestation will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for Late Miscarriage, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 20+0 to 23+6 weeks gestation will be audited in line with the annual audit programme, as agreed by the CBU.

11.0 Equality and Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. The guideline for Late Miscarriage, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 20+0 to 23+6 weeks gestation should be implemented with due regard to this commitment.

To ensure that the implementation of this the guideline for Late Miscarriage, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 20+0 to 23+6 weeks gestation does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

The guideline for the Late Miscarriage, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 20+0 to 23+6 weeks gestation can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing the guideline for Late Miscarriage, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 20+0 to 23+6 weeks gestation. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend

appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

12.0 Recording and Monitoring of Equality & Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, the guideline for Late Miscarriage, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 20+0 to 23+6 weeks gestation will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

1

Patient Bereavement Leaflets:

BHNFTPL0233 When Baby Dies ONE Oct 19 DL .pdf

BHNFTPL0234 When Baby Dies TWO Oct 19 DL .pdf

BHNFTPL0235 When Baby Dies THREE Oct 19 DL .pdf **2**

Table of recommended tests and investigations to be carried out at the point of diagnosis of a miscarriage:

TEST	REASON FOR TEST
MSU	To identify ascending maternal bacterial infection
HVS	
FBC	To assess maternal wellbeing and ensure prompt XXXXXXXX of underlying conditions.
U&E	
LFT	
Serum Uric acid	
CRP	
Coagulation Screen	To identify Disseminated intravascular coagulation (DIC)
Thyroid Screen (TSH)	Thyroid dysfunction and diabetes are thought to be associated with stillbirth. These tests should be performed to identify if the mother has these underlying conditions.
HbA1c	
Anti-Nuclear Antibody (ANA)	To detect undiagnosed autoimmune disease as a possible cause of IUD
Acquired Thrombophilia Screen (Anti Phospholipid Syndrome)	Antiphospholipid syndrome testing is recommended following stillbirth; especially when accompanied by fetal growth restriction, severe preeclampsia, or other evidence of placental insufficiency
TORCH Screen	To identify occult maternal-fetal infection; associated with stillbirth. (Toxoplasmosis, Other (syphilis, varicella-zoster, parvovirus B19), Rubella, Cytomegalovirus (CMV), and Herpes infections)
Kleihauer	To assess for lethal feto-maternal hemorrhage (to be obtained for all women regardless of blood group).
Group and Save	To identify maternal blood group and test for antibodies

Table of recommended tests and investigations to be carried out at the onset of care of women having a **MTOP**:

TEST	REASON FOR TEST
FBC	To assess maternal wellbeing and ensure prompt treatment of underlying conditions.
Coagulation Screen	To identify Disseminated intravascular coagulation (DIC)
Group and Save	To identify maternal blood group and test for antibodies

Appendix 3

Table of tests required for women choosing expectant care of labour:

SCREENING REQUIRED	FREQUENCY
FBC Coagulation screen	Twice weekly

4

Stage 1: Active care of labour; Pre-induction drug regime information:

	Miscarriage 20+0 to 23+6 weeks	MTOP 20+0 to 23+6 weeks	
	Unscarred & Scarred Uterus	**Unscarred uterus**	**Scarred Uterus**
Pre-Induction	Mifepristone 200mg (Once only) **Normal interval between mifepristone and misoprostol is 24 to 48 hours though this can be shortened if clinically needed**		
Induction	Misoprostol 200mcg, (Vaginal/Sublingual/Buccal) 4-6-hourly (4 doses)	Misoprostol 400mcg (Vaginal/Sublingual/Buccal 3 hourly (5 doses)	Consider halving the dose of Misoprostol to 200mcgs 3 hourly (5 doses)
	If not effective, discuss with Consultant - consider repeat misoprostol after 12 hour rest period		
If there is a delay in delivery of the placenta by more than 30 minutes after delivery of the fetus, an additional dose of misoprostol can be given.			

Appendix 5

These tests should be performed on all stillborn babies and sent to histology:

TEST REQUIRED	REASON
Fetal swab (Axilla)	**To detect infection**
Placental swab	

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All keepsakes are stored in the cabinet in the Bereavement Suite. Each item should be explained to the family so that they understand its' purpose. The following options are available to our families for creating memories and keepsakes:

MEMORY MAKING ITEM/KEEPSAKES	
4Louis Memory Box	**Memory box for parents** The boxes contain items to help inspire bereaved families to capture mementos of their baby.
Jaxon's Gift Memory Box	**Memory box for siblings of the baby** These boxes should be offered to children who have lost a baby sibling to try and help them make sense of the loss.
Remember My baby	**Remembrance Photography service** 'Remember My Baby' is a registered charity which offers a free baby remembrance photography service to parents experiencing the loss of their baby before, during or shortly after birth.
Hand/foot prints	The hand/footprint kits are provided by SANDS They are included in the 4Louis memory boxes or available separately from the bereavement cupboard on the birthing centre.
Aching Arms bear	Aching Arms bears are intended to provide a physical comforter for mothers and to signpost parents to support agencies to ensure they have high quality bereavement care, support and counselling.
Henrys Hope 3D Hand & Foot castings	A local baby loss charity, Henry's Hope, provide this service as part of a memory making session, they will visit the Rainbow Room and create the casts together with the family. The casts are presented either in a box frame or gift box with personalisation of baby's name, date of birth and weight etc. Providing a most special keepsake that will last forever.
Little Angel Ashes soft toy	Parents who choose to have their baby cremated, may choose to purchase a small container from the Bereavement Office at the crematorium in which to keep their baby's ashes. 'Little Angel' soft toys are available, with a zip compartment where the container of ashes may be discreetly stored. These soft toys make the perfect comforter for parents to hold their baby close.
Hand in their Heart Keyring	This is a beautiful keepsake keyring, with a cut out heart, designed as gift for bereaved parents. The tiny heart can be placed in the baby's hand or blanket when saying goodbye and the keyring is a gift to the parents, as a beautiful tangible reminder of the connection shared with their baby.

Lexi Doll	Lexi doll's may be given to children who had all the expectation of a new baby coming into the family. Giving children something special to hold, cuddle and play with remembering their baby who passed away.
Treasured Blessings	The Treasured Blessing Box includes special treasures and items that can be used to create a special and comforting moment between a family and their baby. The unique words and treasures are made especially for parents who have lost a baby. The special moment is similar to a blessing, which is unique each family, their baby and their beliefs and ideas

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Table below suggests recommended literature to be included for bereaved women at point of discharge:

DISCHARGE PACK CONTENTS	
Mothers Postnatal Notes & Handover of care	Discharge packs are pre prepared and ready for completion for each individual patient
Leaflets for local and national bereavement support groups	
Stillbirth Certificate	
Release form	
Details to access the Facebook support group 'The Rainbow Room'	
Information about bereavement counselling services	
Contact details for Bereavement Midwife	
Information for Parents Following Bereavement; Leaflet 3	
Stillbirth certificate Instruction on registering stillbirth	
PMRT Investigation letter (Losses from 22+0 only)	

Appendix 8

Task and Documentation checklist for Late miscarriage or MTOP (20+0 to 23+6)
LATE MISC BEREAVEMENT CHECKLISTS AUG 2022.pdf

Appendix 9 Neonatal Death Task and documentation checklist

NND BEREAVEMENT CHECKLISTS AUG 2022.pdf

Appendix 10

For pregnancy losses up to 23+6 weeks gestation (excluding neonatal deaths). The hospital offers the parents a Sensitive Cremation of the fetus. There is no option for burial unless parents wish to make their own arrangements.

FUNERAL DOCUMENTATION

TYPE OF FUNERAL:	DOCUMENT:	COMMENTS:
CREMATION	**Parental Wishes form**	See documentation checklist for instruction of distribution of each colour copy
	Certificate of medical Practitioner/Nurse/Midwife in respect of application for cremation of foetal remains	See documentation checklist for instruction of distribution of each copy

Appendix 11

At the follow-up consultation possible areas for discussion include the following. However, this needs to be done sensitively to the woman's individual needs:

FOLLOW UP APPOINTMENT:
Results of tests/investigations for miscarriage/MTOP
Likely cause of miscarriage
Pre-pregnancy plan for next pregnancy
Smoking/alcohol status
Folic acid advice, consider low dose aspirin
BMI optimisation
Any psychological issues/ support required
Medications
Optimisation of other medical conditions
Plan for next pregnancy
Who to contact in next pregnancy
Book under Consultant Obstetrician
Screen for gestational diabetes (if unexplained)
Ultrasound scan schedule
Place/type/timing of delivery for subsequent pregnancy
Consider extra precautions for post-natal depression
Feedback of the findings from PMRT/case review/serious Incident investigations

It is recommended that the meeting is documented in a letter to the parents, and copied to their GP, including an agreed outline plan for future pregnancy.

Appendix 12 Equality Impact Assessment – required for policy only

Please refer to Equality Impact Assessment Toolkit – found in Corporate Templates on PC desktop.

For clinical policies use Rapid Equality Impact Assessment Form

For all other policies use Equality Impact Assessment Blank Template

Appendix 13 Glossary of terms

List all terms/acronyms used within the document and provide a summary of what they mean.

Appendix 14 (must always be the last appendix)

Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Reviewed by Maternity Guideline Group	
Reviewed at Women's Business and Governance meeting	
Approved by CBU 3 Overarching Governance Meeting	
Approved at Trust Clinical Guidelines Group	
Approved at Medicines Management Committee (if document relates to medicines)	N/A

Trust Approved Documents (policies, clinical guidelines and procedures)
Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Guideline
Document title	Late Miscarriage, MTOP and Early Neonatal Death from 20+0 to 23+6 weeks gestation.
Document author (Job title and team)	Bereavement Midwife
New or reviewed document	Reviewed
List staff groups/departments consulted with during document development	
Approval recommended by (meeting and dates):	**WB&G : 21/10/2022 CBU3** **B&G : 02/11/22**
Date of next review (maximum 3 years)	02/11/2025
Key words for search criteria on intranet (max 10 words)	Bereavement Medical termination
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the FINAL version of this document	**Name: Molly Claydon** **Designation: Governance Support Co-ordinator**

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): **Date approved:** **Date Clinical Governance Administrator informed of approval: Date uploaded to Trust Approved Documents page:**