

Fetal Loss and Early Neonatal Death Guideline

VERSION 5.1

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Obstetric Consultant Bereavement Lead

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		non-compliance with this SOP.		
4.9	23 rd December 2024	Additional criteria for safe outpatient management	Maternity Governance	October 2025
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‘In this guideline we use the terms ‘woman’ or ‘mother’ throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth’.

1.0 Introduction

A woman’s relationship with her baby begins long before birth. Grief for the loss of a baby can be experienced at any time during pregnancy or after birth.

When a pregnancy ends, there are a number of common elements and needs associated with the parents’ experience of loss. Some aspects of grief are individual and very private.

Please note, this guideline refers to MTOP for fetal anomaly at any gestation of pregnancy and fetal losses from 16+0 weeks gestation (Refer to EPAS guidelines for management of early fetal loss below this gestation) as well as early and late neonatal deaths. For post neonatal deaths including SUDIC (Sudden unexplained death in childhood) please refer to paediatric guidelines). This guideline works in partnership with several neonatal SOPs and guidelines including Child Death Process, Neonatal Mortality SOP, Neonatal Palliative Care, Confirmation of expected death of a baby on the Neonatal Unit, Death and Seriously Ill Babies as well as Determination of Signs of Life.

2.0 Aims

2.1 To treat parents and babies with respect, sensitivity, and dignity.

2.2 To provide physical and psychological support during and following diagnosis and management of fetal loss.

3.0 Objectives

3.1 To support parents and to facilitate, as far as possible, their individual needs.

3.2 To provide clear guidance for staff caring for bereaved women and their partners

4.0 Definitions/abbreviations

4.1 Intrauterine death: Fetal death in utero, before birth.

4.2 Stillbirth: Birth with no signs of life after 24 completed weeks of gestation except when death is known to have occurred in utero before 24 weeks

4.3 Non registerable birth: A fetus that has been confirmed as an IUFD (at any gestation) prior to 23+6 regardless of gestation at delivery.

4.4 Early neonatal death: Baby born at any gestation showing signs of life, where death occurs within 7 days of birth.

4.5 Late neonatal death: Death after 7 days and within 28 days of birth.

4.6 post-neonatal death: Death after 28 days and within one year of birth.

4.7 Early fetal loss: Fetal death before 22 weeks completed weeks of gestation.

4.8 Late fetal loss: Fetal death between 22 and 23+6 weeks of gestation confirmed on USS prior to delivery.

4.9 MIS Maternity Information System

4.10 MTOP Medical Termination of Pregnancy

4.11 IUFD Intrauterine Fetal Death

4.12 FMS Fetal Medicine Specialist

4.13 NNU Neonatal Unit

4.14 DOH Department of Health

4.15 PM Post-mortem

4.16 RCOG Royal College of Obstetricians and Gynaecologists

4.17 CTG Cardiotocograph

4.18 SI Serious Incident

4.19 MBRRACE Mothers & Babies Reducing Risk through Audit and Confidential Enquiries.

4.20 CDOP Child Death Overview Panel

- 4.21 Middle Grade ST4-7, Staff Grade, Trust Grade Doctor, Associate Specialist Obstetrician
- 4.22 Cuddle Cot Portable cooling system designed to keep the baby cool to preserve condition and dignity after death.
- 4.23 HTA Human Tissue Authority

5.0 Process

When the following events occur the Bereavement Care Pathway within Badgernet and paper checklist relevant to the type of loss should be started to ensure no aspect of care is overlooked.

Non-registerable Births

- Medical Termination of Pregnancy for Fetal Anomaly (MTOP) – Any Gestation
- Early Fetal Loss (From 16w 0d to 21w 6d)
- Late Fetal Loss (22w 0d to 23w 6d)

Registerable Births

- Stillbirth
- Neonatal Death

5.1 Medical Termination of Pregnancy (MTOP)

5.1.1 MTOP is offered for major fetal abnormality. MTOP may also be offered to women with history of premature rupture of membranes or sepsis if clinically indicated. It is a legal requirement that the Certificate A (Abortion Act 1967) is completed by 2 registered doctors to authorise the termination of pregnancy. In addition, following discussion with the woman of the risks and benefits of the procedure, written consent must be obtained using the generic consent form. A copy of the consent form will be filed in the maternity records and the woman will be given a copy to keep. Certificate A (Abortion Act 1967) form is filed in the women's maternity records and must not be destroyed for 3 years. HSA4 form is commenced by the Specialist Midwives – Bereavement and authorised by the decision-making Consultant. Antenatal NCARDS will be completed by the Sonographers on diagnosis of anomaly and Postnatal NCARDS will be completed by the Specialist Bereavement Midwives after birth.

5.1.2 Organising MTOP: When a fetal anomaly has been detected the woman will have a discussion with the fetal medicine specialist with regards to the on-going pregnancy. If medical termination is requested and agreed, the required paperwork (**see 6.1.1**) will be completed before initiating medical management. If there is an opportunity and the woman wishes, the Specialist Midwife – Bereavement is contacted to meet the woman and answer any questions they may have. When planning admission, liaise with the delivery suite manager or coordinator to ensure capacity and inform the Midwifery Manager of the Day. The woman will be admitted to delivery suite 36-48 hours following Mifepristone, to start the Misoprostol regime. On the day of admission, the woman will be advised to arrive around 10am.

5.1.3 Feticide: Feticide will be offered to all women undergoing MTOP from 20 weeks of completed gestation, whether for lethal or non-lethal conditions, in order to prevent termination of pregnancy resulting in live birth.

5.1.4 MTOP Livebirth and Resulting in Neonatal Death: Following the release of the Chief Coroner Guidance 45 shared in February 2023, it has now become law that any baby born following a termination of pregnancy resulting in a livebirth and neonatal death must be referred to the Coroner. An inquest must then be opened by the Coroner and this is because a child who is born alive and whose death is caused by prematurity following a termination of pregnancy, will have died an unnatural death as discussed within the guidance shared.

If following a termination of pregnancy, signs of life have been observed then the Consultant caring for the woman at the time, would need to refer the case to the Coroner via the online Coroners Portal. If you have not got a login for this system, it is necessary to contact the PALS/Medical Examiner and Bereavement Office Monday-Friday 09:00-17:00 on ext 5819/5316 so you can be supported to make this referral. Following completing the online portal, you may then be contacted by the Coroner Officer and required to complete a Statement for Inquest. Templates are available from Legal Services and once completed must be returned to the legal

team via their email sath.legal.services@nhs.net so that the Statement for Inquest can be securely sent directly to the Coroner Officer. Following the completion of the inquest and any investigations if required e.g. coroners post mortem, the Coroner will then issue the death certificate for the baby and the family can then make funeral arrangements. The Specialist Bereavement Midwives will obtain the Record of Inquest from the PALS/Medical Examiner and Bereavement Office and upload this as a scanned document to Badgernet. For any queries contact the Specialist Bereavement Midwives or you can contact the Coroners Officers directly on 01743 258540.

5.2 Intrauterine Fetal Death (2nd and 3rd Trimester)

5.2.1 Diagnosis: The diagnosis can be made by a practitioner (sonographer or doctor) who has completed appropriate training. Whilst a second opinion may be sought wherever practically possible, it is not mandatory for a second practitioner to confirm the diagnosis unless there is any doubt about the scan findings or that the family request a second opinion. A scan by a fetal medicine consultant or experienced sonographer following diagnosis but prior to induction of labour may help to give more information regarding gestation, anomalies, and potential causes of the stillbirth. Unless requested by the family, this should be a consultant discussion with the woman if it is felt that it would be helpful taking into account individual circumstances.

5.2.2 Breaking bad news: when IUFD is confirmed, the consultant obstetrician on duty will be informed. The woman will be seen by the obstetric consultant or middle tier to plan care. If the woman is unaccompanied, staff will offer to contact her partner, family, or friends to provide support.

5.2.3 Privacy: When possible, care for the woman and family is provided in a private area, ideally the Bereavement Room on the delivery suite. Open visiting from family members is encouraged to provide support.

5.3 Following confirmation of IUFD and prior to admission

5.3.1 Inform the Specialist Midwife – Bereavement via email (sath.bereavementmidwives@nhs.net) or during working hours, they should also be contacted via phone. Please also inform the Midwifery Manager of the Day.

5.3.2 The Bereavement Care Pathway within Badgernet will be commenced.

5.3.3 Bereavement Information Pack will be offered by the obstetrician, midwife caring for the women or the Specialist Midwife – Bereavement (when on duty). Discussion will be supported by the information leaflets given to the family and these discussions will be documented on Badgernet.

5.3.4 In order for the relevant people to be informed at the earliest opportunity a Datix clinical incident form will be completed for all IUFD >16 weeks gestation and neonatal deaths whatever the gestation, in order for the organisation to carry out the appropriate investigations and reporting in a timely manner. The Datix will be completed at the time that the IUFD/NND is confirmed by the person caring for the woman/baby.

5.3.5 Investigations: See Table 1 and Table 2

Clinical assessment and laboratory investigations are recommended to assess maternal wellbeing which may help in determining the cause of the fetal demise. The results may inform risk of recurrence and management in future pregnancies. These tests will be taken following the confirmation of the IUFD regardless of the time or day of the week. Request forms for the blood tests are generated from Review System under “Maternity Bereavement” which indicates each coloured bottle that is required (11 bottles). Some of these test results can take several weeks; the woman should be advised that all available reports will be shared with them at a follow up appointment with the Consultant and Specialist Midwife – Bereavement. FBC, CRP, U&E, LFT's and Clotting Screen should be reviewed prior to discharge home following diagnosis of IUD.

5.3.6 Rhesus Negative Women

If a woman is rhesus negative, Anti-D will be administered **within 72 hours of confirmation of fetal loss**. Note: This could be prior to birth.

Table 1: Investigation recommended for all women with an IUFD at time of diagnosis.

Investigation	Indication	Additional Comments
Biochemistry U+Es LFTs Uric Acid CRP Bile Acids Blood Glucose HbA1c TFTs	Pre-eclampsia and associated complications. Sepsis Obstetric cholestasis Occult diabetes Thyroid disease	HbA1c is inaccurate in anaemia.
Haematology FBC Coagulation Screen and Plasma Fibrinogen Lupus Anticoagulant Cardiolipin Antibodies	Haemorrhage DIC Antiphospholipid antibodies	Maternal sepsis, placental abruption and pre-eclampsia may cause DIC.
Kleihauer Test	Diagnosis and quantification of foeto– maternal haemorrhage.	Kleihauer test is recommended for all women to diagnose Fetomaternal haemorrhage (ensure laboratory aware if a woman is RhD-positive). RhD-negative women with a positive test will require additional anti-RhD immunoglobulin.
Serology Viral screen for CMV, Toxoplasmosis, Rubella, Parvovirus	Occult maternal-fetal infection	Stored serum from booking tests can provide baseline serology
Bacteriology Blood cultures MSU Vaginal Swabs	Suspected maternal bacterial infection	Indicated in the presence of fever, flu like symptoms, signs of chorioamnionitis.

Table 2: Additional investigations if clinically indicated

Investigation	Indication	Additional Comments
Maternal Alloimmune Platelet Antibodies	Alloimmune Thrombocytopenia	Indicated only if fetal intracranial haemorrhage found on post mortem
Maternal Thrombophilia Screen	Maternal Thrombophilia	Indicated only if evidence from placental histology
Maternal anti-Ro and anti-La Antibodies	Occult maternal autoimmune disease	Indicated only if evidence of hydrops, endomyocardial fibro-elastosis or AV node calcification at post mortem
Anti-red Cell Antibody Serology	Immune Haemolytic Disease	Indicated only if fetal hydrops evident

5.4 Options for Birth

If the woman is clinically well (MEOWS =0), with intact membranes and no evidence of infection or bleeding, discuss the options of birth (she will be offered the choice of prompt induction of labour, expectant management, or caesarean section). If there is evidence of ruptured membranes, infection or bleeding, immediate induction of labour or caesarean birth is recommended. Women will be offered the Bereavement Birth Preferences Card to aid the decision making process on her birth and memory making options if appropriate.

5.4.1 Induction of Labour

Induction of labour is usually achieved using a combination of Mifepristone and Misoprostol or Mifepristone followed by use of a Cervical Ripening Balloon. Mifepristone is anti-progesterone which increases the sensitivity of the uterus to prostaglandin, it is a controlled drug. When the woman prefers not to wait 36 – 48 hours, Misoprostol can be administered without prior Mifepristone, but the induction process may take longer, and a second course of Misoprostol may be required.

5.4.2 Initial Outpatient Management

Once all of the information leaflets have been provided and maternal investigations have been taken, if determined safe and appropriate to proceed with the medical management and the woman agrees with her plan of care, medical management will be administered via the following:

Table 3: Oral medication doses for medical management

Stages of Pregnancy	Dose of Oral Mifepristone
2 nd and 3 rd Trimester	Mifepristone 200mg (PO) (Followed by Misoprostol 36-48hrs later. See table 4)

Prior to the administration of Mifepristone, the woman will be informed of the possible side effects of nausea, vomiting and abdominal pain which will form part of gaining consent. She will be advised to contact the maternity department for advice if she experiences any bleeding as she may require admission earlier to hospital.

Criteria before going home

- FBC, U&Es, LFTs, CRP and coagulation results will be reviewed to ensure there are no immediate safety concerns. **If any abnormal results are found, these will be escalated to the obstetric team.**
- MEOWS=0
- If a woman is rhesus negative, order Anti-D. It will need to be administered **within 72 hours of confirmation of fetal loss**. Note: This could be prior to birth.

A time and date will be arranged for the woman to return for continued medical management. The woman will be informed of this and provided with contact numbers. A bed will be booked for her to return to delivery suite, where she will be cared for in a dedicated bereavement room. At times of high acuity/escalation this may not be possible, on this occasion a plan of care will be made involving the manager of the day and on call consultant. It may be possible for the woman to remain at home and be admitted when period of high acuity has resolved unless there is a clinical risk to the woman.

5.4.3 Following admission to Hospital

Medical Induction of Labour

Misoprostol is to be administered vaginally as per table 4.

Women should be made aware that the following side effects are a possibility; however, the RCOG suggests that vaginal administration results in fewer side effects:

- Pyrexia
- Diarrhoea
- Retained Placenta
- Hypovolemic Shock
- Nausea and Vomiting
- Abdominal Cramping
- Ruptured Uterus

Most serious complications may include uterine rupture, major haemorrhage, and cervical tear but these are rare.

Table 4: Misoprostol dose is dependent on gestation.

Gestation	Below 20w	20-26+6w	27w Onwards
Dose	First dose 400mcg PV Subsequent doses 200mcg PV <i>Previous C/S first dose 200mcg and subsequent doses 100mcg PV.</i>	200mcg PV <i>Previous C/S 100mcg PV.</i>	100mcg PV <i>Previous C/S 50mcg PV.</i>
Frequency	3 hourly to a maximum of 6 doses	4 hourly to a maximum of 6 doses	4 hourly to a maximum of 6 doses
Also refer to sections below relating to Previous Caesarean Birth and Failed Medical Management			

Mechanical Induction of Labour

If mechanical induction of labour is recommended or chosen, please refer to the induction of labour guideline.

Previous Caesarean Birth

Initial management with mifepristone as described in table 3. However, women will be advised that due to previous caesarean birth there is an increased risk of uterine rupture during the medical management process and women will be given information on this when discussing induction of labour. National guidance recommends that the method used aims to reduce this risk and acknowledges Dinoprostone and misoprostol is contraindicated. For women wishing for induction of labour, the method will be decided on a case-by-case basis by a Consultant only. The methods of induction include:

Mechanical Induction of labour (only method recommended by NICE)

Mifepristone (Whilst approved for induction of labour following IUFD there is no evidence for safety or efficacy in women with a previous caesarean birth and is therefore not recommended by NICE. The option of mifepristone alone may be considered to avoid use of misoprostol or prostaglandins; however, use of mifepristone alone is likely to take longer and have a lower success rate. A randomised controlled trial of oral mifepristone alone (200 mg three times a day for 2 days) resulted in 63% of women delivering within 72 hours.

Misoprostol is still commonly used however does carry increased risk with a previous caesarean section scar (A reduction in the dose of misoprostol (half the dose described in table 4) may be considered however this practice is not within the NICE recommendations).

Failed Medical Management

If delivery does not occur after administration of 6 doses of misoprostol, an individual management plan will be made by the consultant or middle grade obstetrician and documented on Badgernet. This may include delivery by caesarean section, mechanical induction of labour or a second course of misoprostol.

Caesarean Section

For some women they may wish to choose a Caesarean Section birth and the Consultant Obstetrician should discuss the risks and benefits of this option. Timing of Caesarean will be arranged taking into consideration when this can be safely achieved and staff required.

Analgesia

It is vital that a woman experiencing a pregnancy loss is informed of all the options for analgesia that are available and any side effects. Diamorphine or a PCA (if on delivery suite) are offered for pain relief as they provide good analgesia and sedation. All other options will be available, including epidural analgesia unless contraindicated for another medical reason. Ensure the woman's wishes are listened to and given in a timely manner. The pain experienced during the induction of labour process with misoprostol may be intense. In addition to this, the woman will be apprehensive and fearful of labour and the outcome. If the woman wishes, and she is clinically well, then a pool birth may be considered for pain relief.

Sepsis

Women with sepsis should be treated as per the Sepsis in Pregnancy and the Postnatal Period Guideline. Mifepristone would still normally be given however it would be recommended to commence Misoprostol regime without a delay as it is important to remove source of infection as soon as possible. This should be for the decision of the Consultant only and will be considered on individual basis.

Group B Streptococcus Infection

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

Care in Labour

Once in labour all maternal observations are undertaken in accordance with the Care in Labour on Consultant Unit Guideline and recorded on the partogram within Badgernet. All women should receive one to one care on the delivery suite.

Completion of the Partogram

Women admitted to delivery suite with a fetal loss (including terminations of pregnancy) should have observations recorded and progress monitored on a partogram in accordance with the care in labour on a consultant unit guideline. The partogram is to be commenced with:

- The first dose of misoprostol if the woman is having medical management.
- When the woman is admitted with evidence of an inevitable miscarriage.
- When the woman is admitted in labour following confirmation of an intrauterine death.

Monitoring of contractions should be completed manually and if this cannot be achieved then Toco can be used. This equally applies to women labouring in the pool.

Bereavement Care Pathway (Badgernet)

The Bereavement Care Pathway within Badgernet should be completed for every woman who has suffered a pregnancy loss or death of a baby. The Bereavement Care Pathway (Woman)

form acts as a checklist and ensures every aspect of the family's bereavement care is completed from welcoming the family to delivery to memory making and arrangements for the baby.

Once the baby/babies have been born, the Bereavement Care Pathway (Baby) should be completed and again acts as a checklist to ensure every aspect of care has been covered including baby examination.

Paper checklists relevant to the type of loss experienced can be found in the individual packs or on the Intranet. These can be used in conjunction with the Bereavement Care Pathway on Badgernet and must be completed and signed in full. Once the family has been discharged this checklist can be scanned onto Badgernet once completed and filed in the mother's hospital records.

5.5 Post Delivery

Care will be provided according to the Postnatal Care guideline. In the event of a retained placenta, refer to the Retained Placenta Management Guideline.

5.5.1 Presence of an obstetrician or neonatologist

Where a baby is seen to be born alive, a doctor (obstetrician or neonatologist) needs to confirm signs of life and then to confirm time of death/no signs of life in order to complete the necessary certification.

In situations where a baby may show signs of life an obstetrician or a neonatologist should be asked to attend due to the nature of providing a death certificate.

Also refer to Neonatal Guideline Babies Born at Margins of Viability and SOP Determination of signs of life following spontaneous birth before 24+0weeks of gestational age where, following discussion with the parents, active survival-focused care is not appropriate ([Training Video from MBRRACE on Signs of Life](#)).

- Inform Coroner if unable to write a death certificate e.g. in cases where the cause of death is unknown or when a doctor was not present to see the baby when they showed signs of life prior to death. This should be done by a Consultant via the Medical Examiner.
- Discussion with family should take place regarding registration of birth and funeral arrangements.
- Refer to the Child Death Process SOP

5.5.2 Lactation and Loss

Colostrum is produced from around 16 weeks gestation and production continues until the first few days after birth. Women should receive information on lactation from 16 weeks gestation regardless of type of loss.

Lactation Suppression: Non-Pharmacological advice for lactating parents:

- Wear a well supporting bra day and night – for example, a sports bra.
- Breast pads in the bra will help with leaking.
- Sleeping on your back, pillows may help to support the breasts if sleeping on the one side.
- Gentle massage may help, some traditional methods such as cabbage leaves in the bra or using gel packs may help by providing gentle massage.
- A cold compress may help – apply for 15-20 minutes.
- Heat should be avoided as this can lead to leakage (although this may be helpful with painful engorgement and plugging); when showering heat can be avoided by standing with your back to the shower.

- Simple analgesia can help with the discomfort if you are usually able to take these medications – 1g paracetamol four times a day and anti-inflammatory such as ibuprofen 400mg three times a day. These two medications can be taken together.
- Some women like treatments such as acupuncture or homeopathy. There is no evidence of harm with these treatments.
- Gradual weaning of expressing is preferred to abrupt stopping due to increased risk of mastitis and painful engorgement.

Lactation Suppression: Pharmacological Methods for lactating parents:

Cabergoline:

Cabergoline, a dopamine agonist used for hyperprolactinaemia, has previously been shown to successfully suppress lactation in a high proportion of women (>90%) and is well tolerated by many of them. Dopamine agonists are recommended by the Royal College of Obstetrics and Gynaecology for lactation suppression in women who experience a stillbirth. Cabergoline is simpler to use and has less adverse effects than bromocriptine.

Cabergoline has two treatment regimes, depending upon whether one is in the first 24 hours after delivery or after this time. Commonly reported side effects of cabergoline are dizziness, headache, and nausea. Counselling should cover these together with the rarer side effects as documented in the latest version of the British National Formulary. Medication for the lactating parent should be prescribed by the obstetrician caring for the woman. For death outside maternity care and neonatal departments, local arrangements should be in place to provide support and arrange prescriptions, as necessary.

Table 5: Cabergoline Prescription Regime:

Prevention of Lactation	Suppression of Established Lactation
1mg to be taken as a single dose on the first day post-partum.	250mcg every 12 hours for 2 days.
For up-to-date information please see the most recent version of the British National Formulary (BNF).	

Continuing Lactation: Milk Bank Donation

Some mothers will express less as part of their gradual suppression of lactation. Other mothers may choose to continue to express milk in the longer term after their baby has died. If a mother has expressed prior to death, after death or as part of lactation suppression, they may have a supply of frozen or refrigerated expressed breast milk. Milk can be donated formally through milk banks and the United Kingdom has 15 milk banks. Information regarding these can be found via the UKAMB, a charitable organisation that supports milk donation and NHS-recognised milk banks across the UK (<http://www.ukamb.org/>). UKAMB supports the Memory Milk Gift Initiative. It would be best practice to contact the milk bank prior to discussing this option with mothers as there are eligibility criteria and at times banks are unable to accept donations. Having this knowledge prior to discussions can avoid upsetting mothers further by suggesting it as an option and then giving them a sense of failure or disappointment if they are unable to donate. Donation to a milk bank is the safest way to donate milk. Milk may be used for various reasons.

Referral to the local Milk Bank:

- The nearest milk bank to The Shrewsbury and Telford NHS Trust accepting donations from bereaved families is The Human Milk Bank at Birmingham Women's and Children's Hospital.
- Milk Bank donation can be offered to women who have suffered a stillbirth or neonatal death.
- Referral to the milk bank can be made by a health professional or parents can self-refer if they wish via phone on 0121 335 8245 or email bwc.milk.bank@nhs.net.
- In order to maintain records at the Milk Bank, information regarding personal details, contact details, NHS Number and medical history will be requested. Questions will be also asked regarding the parent's lifestyle and will be asked to complete a questionnaire. This is because there are certain reasons that will exclude a parent from being a donor e.g. smoking or taking most prescribed medications.
- Women should be given support around the initiation of expressing their breast milk.
- Women should be advised to get a breast pump, sterilising equipment and have enough room in their freezer to store the breast milk.
- Women should be encouraged to access ongoing support from the Milk Bank directly as they will be able to provide sterile bottles and labels as well as a freezer thermometer if required and temperature record sheets. They will also be able to answer any queries or concerns the family have.
- There is no minimum donation for bereaved parents.
- Women will be asked to have some blood tests completed to screen for infection.
- For any advice contact the Milk Bank directly.

Contraindications to Milk Bank donation:

- Medications – these may be short term contraindications dependant on medication type. Commonly include but not restricted to; anti-depressants, antibiotics, anti-coagulants, pain relief and induction medication following a still birth.
- Smoker in the household.
- Donor uses nicotine replacement therapies or smokes.
- Alcohol consumption more than 1-2 units of alcohol once or twice a week.
- Caffeine intake of more than 200mg per day.
- Milk expressed more than 10 weeks previously.
- Blood transfusion/tattoos/acupuncture may contra-indicate a retrospective donation due to delayed blood tests.

5.5.3 Determining sex of the baby

Inform the parents that determining the baby's gender is not always obvious at gestations less than 20 weeks and that we would not routinely allocate a gender under 20 weeks. A gender may already be known from ultrasound scan. Documentation within Badgernet for gestations less than 20 weeks should be described as indeterminate unless obvious. If parents wish to know the gender prior to the funeral taking place this can be confirmed usually once the provisional post-mortem results are received if these investigations were undertaken, and on occasion the gender may be different to that originally thought. If post-mortem consent is not obtained the parents will be advised that the gender cannot be confirmed.

5.5.4 Stillbirth Certificates including their retention.

- Following a Stillbirth, the Midwife or Obstetrician caring for the woman should complete the Stillbirth Certificate.
- Copy of the certificate to be given to parents by Dr/Midwife/Nurse
- Original copy to be given to the Specialist Midwife – Bereavement who will then scan and send the certificate directly to the Registry Office via their online portal (**See appendix 12 for instructions**).

- Certificate to be checked by Bereavement Midwives prior to sending for completeness (no abbreviations accepted)
- Both sides of the certificate must be scanned prior to sending via the online portal.
- Once the certificates have been scanned and sent via the online portal to the Registrar, the Registrars will check the document and once accepted will then send an email directly to the family to arrange an appointment for Registration.
- Family members (the informant or next of kin) will again have to register the stillbirth in person or by declaration.
- If the Specialist Midwife for Bereavement is not available, the original certificate can be scanned and sent to the Registry Office via the portal by a Midwife/Doctor/Nurse and then filed securely in the maternity records for a stillbirth.
- Scan copy of certificate on to Badgernet system
- Email address for Register Office if required for advice:
Register.office@telford.gov.uk

5.5.5 Post-mortem Examination

A detailed post-mortem examination of the baby can be offered to families from 12 weeks gestation dependant on clinical picture.

Parents are advised that a post-mortem examination may provide more information than other less invasive tests. However, a post-mortem examination may not identify the cause of death, and this must be explained. Individual, cultural, and religious beliefs must be respected when discussing post-mortem.

Consent: Detailed written consent for post-mortem examination is required from a parent, preferably the mother, regardless of gestation. **Consent must be taken by a doctor or midwife who has received the relevant training.** Consent must be recorded on the approved document. Prior to obtaining consent, parents will be given time to read the patient information leaflets on post-mortem examinations and ask questions. **The yellow part of the post-mortem consent form is given to the parents, blue part filed in the medical notes and grey part is sent with the baby.**

Placental Histology: When consent for post-mortem is declined, parents may give written consent for placental histology. A histology form and clinical information for fetal/perinatal post-mortem form will be completed. Genetics can also be offered if clinically indicated and a separate genetics request form will be completed.

Results from Post-mortem or Placental Histology:

Results for post-mortem can up to 6 months and placental histology can take longer. Ensure the parents are aware of this. While the post-mortem examination is being carried out, the baby will be away for approximately 2 weeks, but this could extend. Check with receiving hospital for up-to-date timings.

5.5.6 Funeral Arrangements

	<24 weeks inc MTOP	Stillbirth	Neonatal Death
Hospital Cremation	✓		
Private Cremation	✓	✓	✓
Private Burial	✓	✓	✓
Home Burial *certain conditions apply	✓	✓	✓

Definitions of Funeral Arrangements:

- **Hospital Cremation:** This takes place at Emstrey Crematorium Shrewsbury and is funded by the hospital, no hospital arranged cremations are performed at Telford. The application for cremation will be completed by a Midwife or Doctor and signed by the mother only. If the family wishes the hospital to arrange the cremation at Emstrey Crematorium, parents need to be aware that the cremation will be carried out with other babies and understand that following the cremation it is not possible to recover any individual remains and any remains retrieved from the shared cremation will be dispersed into the garden of remembrance. Prior to the cremation taking place the hospital chaplain will bless the babies.
- **Private Cremation:** Arranged through Funeral Director (Family need to liaise with them) and this is financed by family. Cremation can take place at Emstrey (Shrewsbury), Telford Crematorium or a crematorium of choice with the appropriate completed cremation form.
- **Private Burial:** The family should liaise with a Funeral Director of their choice who will plan burial according to their wishes. The burial form should be completed and marked as private burial.
- **Burial outside a Cemetery:** SANDS guidance states that there is no legal prohibition to parents taking remains home to bury themselves provided the following requirements are met:
 - It must not cause danger to others
 - It must not interfere with any rights other people may have on the land
 - There must be no danger to water supplies or watercourses
 - There must be no chance of bodily fluids leaking into or on top of adjoining land.
 - The fetal tissue must be buried at a depth of at least 45 cm.
 - Permission must be obtained from the landowner if the parents do not own the land.
 - Careful thought must be given when considering burial in a garden, taking into account what would happen if the parents moved house, or the land was used for new purposes in the future.

The baby must be sent to the mortuary and the parents will be advised when they can collect the fetal remains (parents will be required to sign paperwork in the mortuary).

When parents have not decided on funeral arrangements:

Where the woman has not made a decision about funeral arrangements within 12 weeks of the pregnancy loss or termination (non-registerable births), the hospital responsible for the woman's care should make arrangements in line with this guidance. The woman should be made aware of the time period when first given information about their options of cremation or burial.

Records of how and when the remains were disposed of, including, where relevant, the name of the cemetery or crematorium, should be maintained by the hospital in order that full information may be provided at a later date if requested.

5.5.8 Care of Baby

- Following the birth of the baby, examination of the baby including weight should be undertaken as well as weight of the placenta. The examination findings including any visible abnormalities found should be documented on Badgernet.
- The baby should have two labels with the mothers' details.
- The parents will be offered the opportunity to see, hold and be involved their babies care if they wish to.
- Offer memory making including photographs, hand and foot prints, clay prints and memory box if appropriate.
- Written consent should be obtained from the mother before photographs can be taken on the digital camera. Photograph the consent form with the woman's details clearly documented. Once photos have been taken, attach the SD card to the

consent form and keep in the Woman's records to be collected by the Specialist Midwives – Bereavement. Each baby will have its own memory card which will go to the medical illustration department to be developed. If the family do not wish to have their photos straight away, they will be filed in the Woman's notes until they are ready to collect.

- Remember My Baby can be contacted via their website to attend and take professional photographs for babies born >24 weeks.
- Ensure baby is dressed in appropriate clothing e.g. gown or angle pocket and place in Moses basket or cool cot if the family wish to keep their baby with them.
- If the family do not wish to see baby, the baby can be kept in the cool storage unit on delivery suite until they are discharged home.
- Once woman is discharged home, baby should be placed in an appropriately sized mortuary cardboard box for their gestation and amount of belongings e.g. teddies which will be kept with the baby at all times.
- Two death cards should be completed. One should be placed in the cardboard box and one should be secured to the top of the box.
- If post-mortem is required complete the appropriate paperwork and ensure the baby and the placenta which will be in a separate white bucket will be placed in a clear plastic bag with the relevant documents.
- Complete the specimen fridge log and transfer to mortuary log. Ensure two maternal demographic stickers are placed with the transfer to mortuary log for the porters to take to the mortuary for their register.
- If the baby is not having a post mortem, the baby can be transferred to the mortuary and the placenta can either be discarded or if for placental histology/genetics can be sent to BWH directly with hospital transport as per the parents' wishes.

5.5.9 Legal Requirements

It is a legal requirement to register the birth of all babies born at 24 or more completed weeks of gestation. The only exception is when death is known to have occurred in utero before 24 weeks of gestation. If a baby is born showing signs of life at any gestation, this is classed as a neonatal death and therefore will be required to have their birth and death registered. For this the Child Death Process SOP should be followed.

5.6 Bereavement Care Before, During and After the Death of a Twin, Triplet or More.

During the antenatal period, all health professionals should continue to offer support to families who have lost one or more babies during pregnancy. This is particularly important if a family still have an ongoing pregnancy.

It is very beneficial for the Specialist Bereavement Midwives to be notified by the Consultant, Midwife Sonographer or Midwife of the demise of one or more babies during pregnancy. This is so support can be offered to the family if they wish to access this. If the family wish to meet or have a telephone conversation this can be arranged and conversations may include what baby may look like, investigations, funeral arrangements and memory making.

When one or more babies have died during a multiple pregnancy and one or more babies has also survived, parents may experience mixed feelings during the labour and after birth. Some parents may feel torn between experiencing joy for the impending birth of any surviving babies and intense grief for the baby or babies who have died. Some parents may not feel able to grieve until after their babies are born when they are able to say goodbye to the baby or babies who have died. They may also have been concerned that their grief would affect any surviving babies before the birth. Staff should acknowledge the baby who has died and avoid focussing on the baby or babies who have survived during and after the labour and birth. Staff should also offer parents opportunities before, during and after the labour and birth to discuss how they are feeling. If there is likely to be a body, recognisable remains of the baby or babies who have died or a fetus papyraceous, staff should offer to gently describe to parents how the baby or babies may look. Many parents do not regret seeing their baby or babies even if their appearance has deteriorated or they have a visible anomaly.

After Birth and Death of One or More Babies in a Multiple Pregnancy

- Parents should be offered the opportunity to spend time with their baby/babies. If they don't want to see their baby immediately, photographs of the baby can be offered.
- Ask families what the names of their babies are if they have names and use them in conversation.
- Offer the family a memory box.
- Take hand and footprints and clay imprints depending on gestation.
- Offer for families to write in the book of remembrance.
- Discuss funeral arrangements with this family.
- Discuss and offer investigations such as post-mortem or placental histology.
- Use the Butterfly Symbol on the door or cot to acknowledge that the baby is the surviving twin in a multiple pregnancy.

5.9 Spiritual Care

The hospital's chaplaincy team provides spiritual, pastoral and religious care to patients and their families. Whatever their circumstances or beliefs, families may find it valuable to have the opportunity to talk with someone in confidence about their feelings or thoughts. Families do not have to be "religious" to talk to a Chaplain. The team are committed to care for each individual and to respect all people regardless of race, religion, creed or belief, gender, culture or lifestyle. The chaplaincy team are also able to provide a religious or non-religious naming ceremony or blessing for babies. Families may want the opportunity to see their own religious leader, and this should be facilitated. To speak to a Chaplain and make arrangement with the team ring switchboard and ask to speak to the on-call Chaplain.

6.0 Bereavement Follow Up

Families should be offered a Bereavement Follow up with their consultant routinely when all investigation reports and results have been received. An earlier follow up can be arranged at the family's request. Bereavement Follow Up appointments should be arranged by the Specialist Bereavement Midwife, and they should attend the appointment to offer support for the family. If there has been involvement from another Trust, then a Joint Bereavement Follow Up may be arranged with them in attendance as well.

7.0 Training

7.1 Midwives and medical staff will be informed about the process for accessing guidelines during their induction.

7.2 Anyone seeking consent for hospital post-mortem examinations should have the relevant experience and a good understanding of the procedure. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations and they should have witnessed a post-mortem examination (Code of Practice A - Consent and Code of Practice B-Post Mortem Examinations, Human Tissue Authority 2017)

7.3 Staff should attend an annual Bereavement Training Update as per the TNA as part of their mandatory training as well as NBCP eLearning module via LMS/e-Lfh at least once.

Bereavement Care after Pregnancy Loss or Baby Death - Learning for All

National Bereavement Care Pathway training sessions have been designed to provide support when talking to bereaved individuals. It offers suggestions and guidance about what to say and do. It is suitable for anyone who might come into contact, in their work or home life, with a person bereaved through pregnancy loss or baby death. This course is available to everyone and currently includes a single session called Introduction to Bereavement Care

Bereavement Care after Pregnancy Loss or Baby Death - Healthcare Professionals

A follow-on from Introduction to Bereavement Care, this course is for healthcare professionals caring for newly bereaved individuals. Working through the themes of the National Bereavement Care Pathway, the course helps healthcare professionals understand the important elements of excellent bereavement care; it covers delivering bad news, memory making, post-mortems and histology, ceremonies and services, discharge, aftercare, feedback, and review. This course currently includes a single session called Principles of Bereavement Care

8.0 Monitoring/audit

Compliance with this guideline / SOP will be audited as part of the Shrewsbury and Telford Hospital NHS Trust's five-year rolling programme of NICE and local guideline audits, unless circumstances require an earlier or more frequent audit. The audit will be carried out using auditable standards and results will be reported and acted on in accordance with the Trust Clinical Audit Policy (CG25).

9.0 References

BAPM (2019) Perinatal Management of Extreme Preterm Birth before 27 weeks gestation.

British Medical Journal (2015) Contact with your baby following stillbirth and parental mental health and well-being. Systematic Review.

Human Tissue Authority (2015) Guidance on the disposal of pregnancy remains following pregnancy loss or termination

Royal College of Obstetricians and Gynaecologists: Green top Guideline No 55- Late Intrauterine Fetal Death and Stillbirth

Stillbirth and Neonatal Death SANDS (2016) Pregnancy loss and the death of a baby: Guidelines for professionals 4th Edition.

National Bereavement Care Pathway (2020) <https://nbcpathway.org.uk/about-nbcp>

Twins Trust Bereavement Support <https://twinstrust.org/bereavement.html>

Bereavement Care Before, During and After the Death of Twins, Triplets or More Report (April 2022)

BAPM (2022) Lactation and Loss: Management of Lactation following the death of a baby. A Framework for Practice.



Sensitive and effective communication

Health care professionals can have a positive influence on how parents and families experience their care even if their baby dies.

Parents often replay every detail of what happened around their baby's death and in the following weeks.

Good communication can't take away the pain parents and families feel but it can reduce the impact of trauma, both in the short and long term.

Team Wellbeing

The death of a baby can have a profound and stressful impact on the staff who cared for the baby and family.

It's important to remember your own wellbeing and consider that of your team. Make time for reflection and to debrief, focus on learning lessons and not blame. You and your team members may need support, be kind to yourself and your team and remember self-care.

Sands' helpline is for anyone affected by the death of a baby, including health care professionals.

Communicate Sensitive



Consider the setting

Consider the setting where you talk to families. Ensure the room is private, quiet and comfortable.



Introduce yourself

Introduce yourself: "Hello, my name is..."



Use the baby's name



Ask the parents preference

Ask whether the parents would prefer to be called by their first names, or 'mum' and 'dad'



Speak gently and kindly, conveying compassion



Sit down, use eye contact, and do not rush



Express understanding

Express understanding for the enormity of the situation and your sympathy and regret. Say "I'm sorry"

Communicate Clearly



Take time

Take time to gather your thoughts and be well informed about all options available



Be gentle, clear and honest



Avoid too much medical terminology



Consider your language

Ensure that parents understand what is being presented to them



Be clear about next steps



Listen carefully

Listen carefully to what parents say, and try to answer questions clearly and honestly

Support

t: 0808 164 3332

e: helpline@sands.org.uk

Download the app at

sands.org.uk/app

sands.org.uk



produced in partnership with

Appendix 2

Support and Resources for Families and Staff

Contact details for Specialist Midwives - Bereavement

Office Number: 01952 565953

Urgent queries:

Delivery suite (24hrs)

Tel number- 01952 565924

SANDS (Stillbirth and Neonatal Death Society)

Offers support and information for anyone affected by the death of a baby, before or after birth. National helpline, local parent-led support, literature, and online support.

Tel: 020 7436 7940 (general enquiries); Tel: 0808 164 3332 (support)

www.sands.org.uk

sands.org.uk/app

SANDS Local Support Group - 2nd Tuesday in a month 7:30pm Meeting Point House, Southwater, Telford, TF3 4HS.

Support Group for Dads

Dad Still Standing is an online group created as a way of helping other dads along their journey with grief. To discuss the difficulties we go through in bereavement, both in the immediate aftermath of baby loss and as time moves on.

<https://www.dadstillstanding.com/>

Child Bereavement UK

[When your baby dies | Child Bereavement UK](#)

Helpline: 0800 0288840

Email: helpline@childbereavementuk.org

Saying Goodbye Charity

<https://www.sayinggoodbye.org/>

0300 3231350

Email: support@sayinggoodbye.org

Lullaby Trust

Bereavement support after the death of a baby or child.

www.lullabytrust.org.uk

Support: 0808 8026868

Email: support@lullabytrust.org.uk

Funeral Payments – UK Government

Financial help that is available for individuals on low incomes in England, Wales and Scotland who need help to pay for a funeral that they are arranging

www.gov.uk/funeral-payments

Hope House Children's Hospice

01691 671 999

www.hopehouse.org.uk

IAPT (Improving Access to Psychological Therapies)

Telford and Wrekin: 01952 457415

Shropshire County: 0300 123 6020

Jobcentre Plus-Bereavement Services Helpline

Provides information about benefit claims

03456088601

www.gov.uk/contact-jobcentre-plus

Lily Mae Foundation

Baby loss support service

01676 535716

www.lilymaefoundation.org

Miscarriage Association

01924 200 799

www.miscarriageassociation.org.uk
info@miscarriageassociation.org.uk

Multiple Births Foundation (MBF)

Provides support and information for multiple birth families (including bereavement support)

www.multiplebirths.org.uk
07360 735050
mbf@bcu.ac.uk

Natural Death Centre

Offers support, guidance and advice for families and other individuals who are arranging a funeral, including information about environmentally friendly funerals and woodland burial sites.

www.naturaldeath.org.uk
Helpline: 01962 712690

Aching Arms (Supporting Arms)

07464 508994
Email: support@achingarms.co.uk

Parental Bereavement Leave

Government scheme enabling parents who lose a baby or child to be entitled to parental leave (April 2020)

www.gov.uk/government/news/uk-first-who-lose-a-child-entitled-to-bereavement-leave

Remember My Baby Remembrance Photography

UK-based charity who have professional photographers who voluntarily provide their photography services to parents whose baby dies before, during or shortly after birth.

www.remembermybaby.org.uk
Email: info@remembermybaby.org.uk

Samaritans

Offers confidential support that is available 24 hours a day to people who need to talk.
116 123 (UK) free

Tommy's

Miscarriage, stillbirth and premature birth charity who offer support following a pregnancy loss.

<https://www.tommys.org>
Email: midwife@tommys.org
Support: 0800 014 7800

Twins Trust Bereavement Support Group

Offers support for families who have lost one or more children from a multiple birth pregnancy, birth or at any time.

www.twintrust.org/bereavement

Winston's Wish

Offer support to bereaved children, their families and professionals

Helpline: 08088 020021
www.winstonswish.org.uk

NHS Choices

The UK's biggest health website, certified as a reliable source of health information:

www.nhs.uk
Evidence based information on a wide range of medical and health topics.
<http://patient.info>

TFMR Mamas

Offering support for families who have experienced a Termination for Medical Reason.

<https://www.tfmrmmas.com/>

2Wish

We provide immediate and ongoing support, such as memory boxes, bereavement rooms within hospitals, counselling, play therapy and complementary therapy.

<https://2wish.org.uk/>

Appendix 3 (Beige Paper)

Checklist for Midwives to complete following: Medical MTOP/Early or Late Fetal Loss

Name: Unit Number:		Tick	Sign	Date
Complete Datix	Record datix number			
Offer Bereavement Information Pack	Yes/No			
Take bereavement bloods (if applicable)	Yes/No			
Parents given the opportunity to view/handle baby-	Yes/No Declined View Later			
Offer Digital Photographs (Gain written consent prior to taking photographs)	Yes No			
Inform Consultant Obstetrician (Name of Consultant)	Yes/No			
Contact GP Practice Name of GP-				
Community Midwife Informed – Name of Midwife (Confirm if Home visits are required/requested)				
Notify Health Visitor by email – Shropcom.spoa@nhs.net for Shropshire residents Shropcom.adminleonardst@nhs.net for Telford & Wrekin residents				
If out of area patient, inform Maternity Unit local to patient via Telephone.				
Fertility Service Notified	Yes/No/Not Applicable			
Check discharge details (address and telephone number)				
Discharge entered in ward diary				
Offer support from a Religious Advisor Can be contacted via switchboard 24hrs/day	Yes Not required			
Baby placed in the cool storage unit on Ward 24 prior to transfer to mortuary (paperwork complete)				
Baby not for investigation prepare for transfer to mortuary – (place in box leave baby fully clothed) notify mortuary on ext 4332				
Baby for Post Mortem at Birmingham Women's Hospital-	Place baby in mortuary cardboard box (Dry) Place placenta in separate bucket Consent form completed Clinical summary completed Send relevant scan reports attached to summary Contact Mortuary			
Funeral Arrangements	Hospital Private	Yes/No Yes/No		

Complete relevant Cremation form for Hospital or Private Cremation (form to be signed by Mother of baby) If private burial -form to be signed by Midwife/Doctor			
Inform Bereavement Officer – (PALS Advisor, Pals Office, PRH) using “Parental Wishes” Form (Send via internal post)			
Parents informed of Book of Remembrance. Parents can write own message/words/poem then to be given/sent to Specialist Bereavement Midwife to add to book			
Parents informed of the Gathering of Remembrance held both in the community and the hospital.			
Email the Specialist Midwives - Bereavement if parents would like to be invited/informed when the twice-yearly Gathering of Remembrance will take place. Sath.bereavementmidwives@nhs.net			
Specialist Midwife - Bereavement notified on Ext 5953 leave message if not available			
Discussion regarding natural suppression of lactation to all women and offer of pharmacological methods from 16 weeks gestation • Prescription for Cabergoline Yes/No			
Cancel all outstanding antenatal appointments on PAS Including GTT/USS appts			
Cancel any Anaesthetic referral appt made for women with BMI >40 by contacting the anaesthetic secretaries.			
NBCP - standard Were the family given the opportunity to create memories (If this is possible) foot prints etc. Yes/No			
NBCP - standard Were the parents asked if they would like to create memories was a memory box offered & did the family receive one Yes/No			
NBCP - standard Was a Cuddle cot (cold cot) offered Yes/No (appropriate to gestation)			
NBCP - standard Were the parents aware that they could take Yes/No baby home (if for PM, discuss that families can have this opportunity following any investigations taking place)			
NBCP standard Were the family informed where the baby would be taken after they were discharged home Yes/No			
Non-Registerable birth completed on Badgernet			
Complete medical discharge on Badgernet and forward to GP			
MBRRACE to be completed by Specialist Bereavement Midwife if gestation >22weeks			
On the back of the cover of the hospital records, record the pregnancy loss in the alerts.			

If you have answered ‘No’ to any of the NBCP standard checklist items, please state your reasoning:

Appendix 4 (Pink Paper)

Checklist for Staff to complete following confirmation of IUFD and delivery (Stillbirth >24 weeks gestation)

Name: Baby		Unit Number: Unit Number:	Tick	Sign	Date
Complete Datix		Record datix number: -			
Offer Bereavement Information Pack		Yes/No			
Bereavement bloods taken		Yes/No			
Offer to take Digital Photographs Gain written consent	Do parents wish to be given to be given photographs once processed: Or retained in notes until requested later	Yes/No Yes/No			
Offer "Remember My Baby" Photography to take additional photographs.		Yes/No			
Were the parents given the opportunity to view/handle baby and spend time with their baby NBCP/PMRT standard/PMRT standard		Yes/No Declined View later			
Consultant Obstetrician notified Name of Consultant: -		Yes/No			
Contact GP Practice Name of GP:		Yes/No			
Community Midwife notified – Name of Midwife: Telephone conversation or community visits requested (If out of area patient, inform Maternity Unit local to patient via Telephone.		Yes/No			
Health Visitor to be emailed for information to be shared: Shropcom.spoa@nhs.net Shropshire residents Shropcom.adminleonardst@nhs.net Telford & Wrekin residents		Yes/No			
Religious Advisor support offered & requested to attend Contacted 24hours/day via Switchboard		Accepted Declined			
Fertility Service Notified		Yes/No/N/A			
Stillbirth certificate to be completed by a Doctor or Midwife following examination of baby and findings to be documented on Badgernet <ul style="list-style-type: none"> • Scan original certificate to Badgernet • Copy of Stillbirth Certificate to be given to parents • Original copy to be scanned and sent to the Registrars via the online portal (see Fetal Loss and NND Guideline Appendix 12). • Parents to be given information re registration of stillbirth 		Yes/No Yes/No Yes/No Yes/No			
Information to be given to parents re Postmortem examination Post-mortem consent obtained by trained professional Post-mortem declined Verbal consent gained for placental histology		Yes/No Yes/No Yes/No Yes/No			
Baby for Post-Mortem in Birmingham		Clinical summary sheet completed Attach copy of all scan reports Consent form completed (grey copy to be attached to clinical summary form) Blue copy file in maternity records Yellow copy given to Parents Relevant paperwork to be placed in envelope marked BWH (to go with baby) Inform Mortuary ext 4332 Parental wishes form to be taken to PALS - Bereavement Services to arrange transfer to Birmingham (CJ Williams – Funeral Directors)			

Funeral arrangement options discussed Arrangements to be made by family	Private cremation Private burial			
<ul style="list-style-type: none"> Complete a burial or cremation form (signed by Midwife or Doctor) Attach completed form to Parental wishes form for Mortuary. Baby to be transferred to Mortuary dressed in appropriate mortuary cardboard box. 				
Inform Specialist Midwife - Bereavement	If not available leave message on answerphone Ext 5953			
Inform PALS Advisor using "Parental Wishes" form Send to: PALS Advisor, PALS Office, PRH. This form needs to be hand delivered to PALS Office if baby is for PM as they will need to liaise with Funeral Directors re transfer to BWH (Monday - Friday only)				
Parents informed of the "Book of Remembrance" Yes/No Parents can write a message/verse/words/poem and send it to Specialist Midwives to add to book				
Parents informed of the Gathering of Remembrance held both in the community and the hospital. Would family like an invitation to this service Yes/No Email to be sent to sath.bereavementmidwives@nhs.net if family would like invite.				
Anti D given if required (Negative blood group) Yes/No				
Discussion regarding natural suppression of lactation to all women and offer of pharmacological methods •Prescription for Cabergoline given Yes/No Discuss milk bank donation if may be eligible (see guideline)				
NBCP/PMRT standard				
Was Cool cot (Cuddle cot offered) Yes/No				
Was the Cool Cot used Yes/No				
SANDS Bereavement Support Book given Yes/No				
NBCP/PMRT standard/PMRT standard				
Were parents given the option of taking baby home or transferring to Hope House Hospice. If for post mortem, discuss with family that this opportunity can happen following any investigations taking place Yes/No Refer to SOP Taking your baby home Yes/No				
NBCP/PMRT standard/PMRT standard				
Were the parents informed where the baby would be transferred to after mother was discharged e.g. Mortuary/Swan Bereavement Suite Yes/No				
NBCP/PMRT standard/PMRT standard				
Were the parents offered a Memory box and was this accepted Yes/No				
NBCP/PMRT standard/PMRT standard				
Were the Parents given the opportunity to make create memories e.g. hand & footprints/bathing baby/photographs/bathing baby Yes/No				
MBRRACE Number				
Specialist Midwife – Bereavement to complete				
Cancel all outstanding appointments on PAS including Antenatal Clinic appt/USS/GTT				
Cancel any Anaesthetic referral appts made for women with BMI >40 by contacting the Anaesthetic Secretaries.				
Complete MIS Badgernet (registerable birth)				
Check discharge details and telephone number				
Complete medical discharge on badgernet forward to GP				
Perinatal Mortality Review Tool to be commenced by Specialist Midwife Bereavement				
On the back of the cover of the hospital records, record the pregnancy loss in the alerts.				

If you have answered 'No' to any of the NBCP standard checklist items, please state your reasoning: _____

Appendix 5 (Blue Paper)

Checklist for Staff following a Neonatal Death on Neonatal Unit or Delivery Suite

Name of Baby Name of Mother	Unit number of Baby: Unit number of Mother:	Tick	Sign	Date
Complete Datix	Record datix number:			
Offer Bereavement Information Pack including information on Child Death Process Yes/No				
Consider taking bereavement bloods				
Parents given the opportunity to view/handle baby	Yes/No Declined View Later			
Gain written consent for digital photographs to be taken Do parents wish digital photos to be given to them following processing or retained in notes: Offer for "Remember My Baby" Photography to attend.	Yes/No			
NBCP/PMRT standard/PMRT standard Was a Cool/Cuddle Cot offered and used (refer to appendix 5)	Yes/No			
NBCP standard/PMRT standard Were parents given the option of taking baby home or transferring to Hope House Hospice (if for PM, examination to be undertaken first). Refer to Fetal Loss and Neonatal Death Guideline for Process	Yes/No			
NBCP standard/PMRT standard Were the parents informed where the baby would be transferred to after mother was discharged e.g. Mortuary/Chapel of Rest	Yes/No			
NBCP standard/PMRT standard Was a Memory box offered to the parents and did they accept one Were parents asked about creating memories Bathing baby/taking hand & footprints etc	Yes/No			
NBCP standard/PMRT standard Were the parents given the opportunity to spend time with their baby	Yes/No			
Inform Obstetrician – Name: Neonatologist Name:	Yes/No Yes/No			
Contact GP Practice Name of GP:	Yes/No			
Community Midwife informed – Name of Midwife Confirm if home visits are required.	Yes/No			
If out of area patient, inform Maternity Unit local to patient via Telephone.	Yes/No			
Health Visitor to be emailed for information to be shared: Shropcom.spoa@nhs.net Shropshire residents Shropcom.adminleonardst@nhs.net Telford & Wrekin residents	Yes/No			
Fertility Service Notified	Yes/No/N/A			
Religious Advisor support offered & requested to attend Contacted 24hours/day via Switchboard	Yes/No			
Coroner Informed	Yes/No			
Consent for Post Mortem obtained	Yes/No			

<p>Death of baby documented on Badgernet and baby's medical records including date and time. <i>NB if neonatal death in delivery room - may document in badger delivery room death section. However all Neonatal deaths where active care undertaken must have neonatal notes raised also (including delivery room NND).</i></p>		Yes/No			
<p>Neonatal consultant complete immediate decision making proforma (see Child Death Process SOP)</p> <p>(Email to governance lead, mortality lead and governance team)</p>		Yes/No			
<p>ME referral made by obstetric/neonatal consultant:</p> <ul style="list-style-type: none"> • Child Death ME Notification form (see Child Death Process SOP) completed & emailed to sath.medicalexaminers@nhs.net • Name & mobile no. of the of Lead Consultant must be included on notification form • Lead consultant to discuss the ME process with family • Lead consultant to give ME relative information to relatives 		Yes/No			
<p>Death summary dictated by neonatal consultant. Secretaries to Send to GP, obstetrician, CDOP nurse specialist, parents, bereavement midwives. <i>NB Death summary must be completed for all neonatal deaths where active care attempted, including labour ward deaths.</i></p>		Yes/No			
<p>For known cause of Death certificate to be completed by Doctor following examination of baby and findings to be documented on Badgernet</p> <p>Scan the MCCD to the ME service email (along with ME referral form) (The ME will review the MCCD and information. The ME will forward the MCCD to the Registrar once they have reviewed the notes and agree with the MCCD).</p> <p>ME service with email the lead consultant and the keyworker (bereavement midwife) regarding outcome of MCCD</p> <p>Key worker (bereavement midwife) to contact family to confirm final cause of death.</p> <ul style="list-style-type: none"> • Give parents information re registration of livebirth and death – key worker. <p>For deaths where cause of death not known or concerns: Discuss with ME and refer to the coroner next working day (responsibility will be lead Neonatal Consultant.</p>		Yes/No			
<p>Baby for Post Mortem (in a white box). Ensure 2 white cards are completed, 1 inside the box and the 2nd taped to lid of the box.</p>	<ul style="list-style-type: none"> • Consent form completed & signed • Clinical summary form completed • Mortuary aware baby for Birmingham Ext. 4332 (leave message if out of hours) • Contact: PALS Advisor on ext. 4382 Mon – Fri to arrange transfer to Birmingham Women's Hospital • Copy of parental wishes form to be handed delivered to PALS office 				
<p>Baby not for investigations: -</p> <ul style="list-style-type: none"> • (Place baby in a white box with 2 x completed white cards, • 1 inside the box and 1 taped to the lid. • Completed paperwork in envelope. 2 x ID Stickers for mortuary. • Baby to mortuary direct from NNU with porter • Baby to Labour Ward Cool Storage Unit <p>Complete transfer to Mortuary form with porter if baby leaving from NNU</p>		<p>Yes/No</p> <p>Yes/No</p>			

Private Funeral Arrangements discussed leaflet given	Yes/No	Private funeral arrangements - Burial or Cremation (please circle appropriate choice)	Yes/No			
Complete appropriate burial or cremation form To be sent to Mortuary with baby (attach to parental wishes form)						
Complete Parental Wishes form, send to mortuary with baby (Include burial or cremation form in same envelope)						
Second copy of parental wishes form to be sent to PALS Advisor, PALS Office, PRH (If baby for PM hand deliver form to PALS office they will arrange funeral director to transfer baby to BWH).						
Parents informed of Book of Remembrance Parents can write a message/verse/words/poem and send it to Specialist Midwives to add to book			Yes/No			
Parents informed of the Gathering of Remembrance held both in the community and the hospital. Would family like an invitation to this service Yes/No Email to be sent to sath.bereavementmidwives@nhs.net if family would like invite.						
SANDS Bereavement Support Book given			Yes/No			
Notify Bereavement Midwife (Out of hours leave message on landline ext 5953)						
Neonatal Consultant to complete notification to CDOP via eCDOP (https://www.ecdop.co.uk/WestMercia/Live/public) and once notification sent, eCDOP will generate an email to the referrer to complete Form B.						
Cancel all outstanding appointments on PAS						
Discuss natural suppression of lactation and medication (Cabergoline). Consider milk bank donation if eligible						
Send copy of Badgernet labour and delivery summary, discharge summary and Neonatal discharge summary to GP						
MBRRACE to be completed by Bereavement Midwife Perinatal Mortality Review Tool Commended (by Bereavement Midwife)						
On the back of the cover of the hospital records, record the pregnancy loss in the alerts.						

If you have answered 'No' to any of the NBCP standard checklist items, please state your reasoning:

Standard Operating Procedure (SOP)

SOP Title	Support for families who wish to take baby home after death.		
SOP Number	Included with Fetal Loss and Early Neonatal Death Guideline		
Care Group	Women's and Children's		
Version Number	2		
Effective Date	15 th September 2023	Review Date	October 2025
Author	Charlotte Tongue and Jan Latham		
Approved by	Maternity Governance		
Approval date	15 th September 2023		
Distribution	All within maternity		
Location	Maternity		

Document Control				
Version	Date	Author	Status	Comments
1	October 2022	Charlotte Tongue	NEW	Introduce New SOP as part of Fetal Loss and Neonatal Death Guideline.
2	15 th September 2023	Charlotte Tongue	Review	
3	20 th March	Charlotte Tongue	Review	Appendix 6 Taking Baby Home SOP update to staff checklist & to include process for families non-compliance with this SOP.
4	September 2025	Charlotte Jackson and Michelle Powell	Full Review	

SOP Objectives	To allow families the opportunity to take their baby home following a pregnancy loss or death of a baby.
Scope	This SOP is to clarify the process when a family wish to take their baby home following a pregnancy loss or death of a baby.
Performance Measures	Monitored as part of the clinical audit and governance process.

Number	Brief
1	<p><u>Introduction</u></p> <p>There is no legal reason why parents should not be able to take their baby from the hospital and make their own arrangements (unless the death has been referred to the coroner). Some families find it very helpful to have the time to take their baby and say goodbye away from the clinical setting and have opportunities for wider family to meet their baby and create memories. Families may want to take their baby home as they may wish to spend time in the home where he or she would have grown up. This is in line with guidance from the National Bereavement Care Pathway and Perinatal Mortality Review Tool.</p>
2	<p><u>Purpose</u></p> <p>This Standard Operating Procedure (SOP) has been produced to ensure that the needs of parents are met and that the appropriate principles for the safe transfer of babies into the community in line with Human Tissue Authority (HTA) guidance are applied.</p> <p>It is important for both parents and staff to be aware that unless a coroner's post-mortem examination is required, there is no legal reason why a baby cannot be taken home after they have died. This choice allows parents an opportunity to spend more time with their baby with the support of family and friends and to say goodbye in their own environment.</p>
3	<p><u>Definitions</u></p> <p>NBCP – National Bereavement Care Pathway PMRT – Perinatal Mortality Review Tool HTA – Human Tissue Authority</p>
4	<p><u>Exclusion Criteria</u></p> <ul style="list-style-type: none"> • Death has been referred to a Coroner. • Infection risk e.g. HIV, Hepatitis. • Significant mental health (reviewed on individual basis). • Learning difficulties. • Safeguarding. • Family do not own private transport (however Funeral Directors may help with this). • Does not agree to requirements as described in Taking Your Baby Home - Parents Letter.
5	<p><u>Equipment Needed</u></p> <ul style="list-style-type: none"> • Cuddle Cot and Deionised Water (if applicable/not being provided by Hope House). • Appropriate container, moses basket or car seat depending on gestation.
6	<p><u>Process in Weekday Working Hours (Monday – Friday 09:00-17:00)</u></p> <ol style="list-style-type: none"> 1) Inform the Midwife in Charge that the family wish to take their baby home, who will then inform the Specialist Bereavement Midwives. Specialist Bereavement Midwives will contact the Hospital Mortuary in preparation for transfer to the Swan Bereavement Suite. 2) Complete Taking Your Baby Home: Checklist for Staff (Appendix 5.4). 3) Contact Hope House if family previously known to them. 4) Specialist Bereavement Midwives meet with the family on delivery suite or neonatal unit and explain process of taking baby home. 5) Ensure families are shown how to use the Flexmort Cuddle Cot if they require one (>20 weeks). 6) Families encouraged to make funeral arrangements with funeral directors and ensure families are aware that they will not be able to bring the baby back to the hospital once the family have been discharged. They can call a funeral director as they can offer on-call support 24/7 as well as Hope House if referral has been made. 7) Family advised to bring car around to outside Mortuary entrance. 8) Parents and baby escorted to Swan Bereavement Suite. 9) Ensure family have a signed Taking You Baby Home: Parents Letter, Parent Information and a copy of the completed Stillbirth or Neonatal Death Certificate (if applicable). 10) Ensure that the Taking Your Baby Home: Log (Appendix 5.5) is completed in the Taking your Baby Home Folder on delivery suite (kept in the locked cupboard next to the cold storage unit). 11) Once discharged the bereavement midwives or community midwives will make daily contact with the family to ensure they are supported. 12) The bereavement midwives will confirm that the baby is with the funeral directors unless criteria for home burial has been met within 3 days of discharge.

7	<p><u>Process Out of Hours</u></p> <ol style="list-style-type: none"> 1) Inform the Midwife in Charge who will then inform the W&C Manager on Call. 2) Manager on Call to inform Executive Manager on Call. 3) Refer family to Hope House for continued support in the community (see Section Number 11). 4) Complete Taking your Baby Home: Checklist for Staff (Appendix 5.4). 5) Ensure Stillbirth/Neonatal Death Certificate is complete prior to discharge and family are given a copy and encouraged to register baby ASAP (if applicable). 6) Ensure families have a signed Taking your Baby Home: Parents Letter and Parent Information. 7) Ensure families are shown how to use the Flexmort Cuddle Cot if they require one (>20 weeks). 8) Families encouraged to make funeral arrangements with funeral directors and ensure families are aware that they will not be able to bring the baby back to the hospital once the family have been discharged. They can call a funeral director as they can offer on-call support 24/7 as well as Hope House if referral has been made. 9) Ensure that the Taking Your Baby Home: Log (Appendix 5.5) is signed with the baby's and parent's full details in the Taking your Baby Home Folder on delivery suite (kept in locked cupboard next to cold storage unit). 10) Email to be sent to the Mortuary (sath.mortuaryprh@nhs.net) to inform them a baby has been taken home out of hours, attaching scanned copy of the completed parents letter. 11) Family to be escorted to car with baby and can use the emergency entrance/exit to delivery suite. 12) Once discharged the bereavement midwives or community midwives will make daily contact with the family to ensure they are supported. 13) The bereavement midwives will confirm that the baby is with the funeral directors unless criteria for home burial has been met within 3 days of discharge.
8	<p><u>Cuddle Cot</u></p> <ul style="list-style-type: none"> • Cuddle Cot to be offered to families whose babies were born >20 weeks gestation. • Family should receive full demonstration before going home with cuddle cot. • Family should be given Information Pack including step-by-step guide on how to set up the Cuddle Cot. • Cuddle Cots are located on Delivery Suite Room 14 and the Antenatal Ward Store Cupboard. • Please refer to Cuddle Cot Set Up and Monitoring SOP via the Intranet for more information on setting up and monitoring the Cuddle Cot. • Once family have finished using the Cuddle Cot, family should contact the Community Midwives or Specialist Bereavement Midwives to arrange collection. If Cuddle Cot has been provided by Hope House, they should contact the Hospice directly to arrange collection.
9	<p><u>Communication</u></p> <p>Inform the following people when a family wish to take their baby home:</p> <ul style="list-style-type: none"> • Midwife in Charge on Delivery Suite. • Manager on Call and Executive Manager (if out of hours). • Hope House (01691 671999). • Specialist Bereavement Midwives. • Mortuary via Telephone in working hours: 4332 or email if out of hours on sath.mortuaryprh@nhs.net. • Community Midwives. • GP and Health Visitors. <p>The Police do not need to be informed if a family wish to take their baby home. Instead, the family should be given a signed 'Taking your Baby Home Letter' to avoid any misunderstanding should any accidents occur e.g. Road Traffic Accident.</p>

10	<p><u>Forms and Information to be given to Parents</u></p> <ul style="list-style-type: none"> • Signed “Taking your Baby Home: Parents Letter” (copy should be filed in the woman’s notes). • Copy of Stillbirth or Neonatal Death Certificate if applicable. • Signed burial or cremation form depending on parents wishes. • “Taking your Baby Home Information Pack” including: <ul style="list-style-type: none"> ○ Taking Your Baby Home: Parents Information (Appendix 5.2). ○ 4Louis Cuddle Cot Instructions if applicable (>20 weeks). ○ Hope House leaflets “Counselling and Bereavement Support” and “When a Baby Dies”.
11	<p><u>Out of Hours Support</u></p> <p>If a family are distressed and feel they need some support once home and particularly during the night/out of hours families can access the following support:</p> <ul style="list-style-type: none"> • If families have been referred to Hope House for support antenatally they are able to call Hope House for advice 24/7 via the main Hope House Number (01691 671999). • If families have been in contact with a Funeral Director and they offer 24/7 call service, families are also able to contact them for support. • Families can call delivery suite on 01952 565924 for advice only. • Bereavement Midwives to be informed of any calls so they can follow up.
12	<p><u>Families non-compliance with this SOP</u></p> <p>In the event that a family do not arrange suitable burial or cremation for their baby in a timely manner (within 3 days), the following steps should be taken.</p> <ol style="list-style-type: none"> 1.) Advise that it is a legal requirement for registerable births to be registered to ensure correct paperwork is in place for baby’s funeral arrangements if not already done so. It is also a legal requirement for registerable babies that appropriate burial or cremation of baby must take place. If the family are refusing to register or have the appropriate arrangements for their baby, the Police and Coroner may take responsibility for baby. 2.) Specialist Bereavement Midwife to inform the Maternity Manager of the Day. 3.) If this was a registerable birth, Specialist Bereavement Midwife to inform the Coroner and Police. 4.) Specialist Bereavement Midwife to inform GP, Community Health Professionals, Named Consultant, Obstetric Clinical Director, Mortality Lead Obstetrician, Lead Neonatologist for baby and Mortality Lead Neonatologist (if applicable).

Taking Your Baby Home – Parents Letter
(Copy to be filed in patients notes)

This is to confirm that the parents: -

Mother's Name: _____ Hospital Number: _____

Signature: _____

Partners Name: _____ Signature: _____

Address: _____

Postcode: _____

Contact Number: _____

Baby's Name: _____ was delivered on: _____ at: _____ gestation.

Have taken their baby from the Hospital Mortuary/Delivery Suite or Neonatal Unit (Out of Hours) at Princess Royal Hospital

To (address): _____

Date: ____/____/____ Time: __:__

I/we the parents take full responsibility for our baby at home. We:

- ☐ Will register our baby's death (if applicable).
- ☐ Have contacted/will contact a funeral director to make arrangements for his/her funeral as soon as possible (within 3 days of being discharged).
- ☐ Confirm that we will return the cuddle cot (if required) to the Trust/will contact the Specialist Bereavement Midwives or Community Midwives to arrange collection.

I/we accept that it will not be possible to return the baby to the hospital once the baby has left the hospital.

Name of authorising member of department releasing baby to the family: _____

Position: _____

Signature _____

Date: ____/____/____ Time: __:__

Taking Your Baby Home – Parent Information

We are sorry to hear that your baby has died and would like to offer you the option of taking your baby home for a few days (1-3 days) to spend some special time together outside the hospital. The potential benefits for parents who take their baby home include:

- Having more time with your baby away from the hospital, giving you the opportunity to say goodbye in the privacy of your own home.
- Time to introduce the baby to siblings, family and friends and to recognise the baby's place within the family.
- Giving you more time to create memories and to gather keepsakes to last a lifetime.
- Giving you time to begin to recover from the shock of your baby's death.

It is important that you feel supported at this time and know who to contact should you require additional support or information. This guidance will provide you with advice on caring for your baby during this time.

Please note that it will not be possible to take your baby home if you have chosen to have a post mortem and it will not be possible to return your baby to the hospital once the baby has left the Trust.

Leaving the Hospital

Before leaving the hospital you will be given a 'Parent Letter' supporting your decision to take your baby home.

This letter confirms that you are:

Taking responsibility for taking your baby home and identifies who you may contact if you have any concerns. The Specialist Bereavement Midwives will guide you through the process and answer any questions you may have.

Safe Transportation

It is important that your baby is transported in a safe and dignified manner. Transport can be undertaken by yourself, a family member or a friend by car or by your chosen funeral director. We would recommend use of an appropriate container, infant car seat or Moses basket secured within your vehicle. Public transport or taxi is not acceptable.

Care at Home

- We advise you to keep your baby cool at home (however not to have windows open or having fresh flowers in the room to minimise the risk of exposure to insects).
- We would also advise that pets are kept out of the baby's room.
- The use of the Flexmort Cuddle Cot will quietly cool your baby, to slow down the expected physical changes which happen following death. Prior to leaving hospital, if applicable, staff will demonstrate how to use the Cuddle Cot at home and you will also be given instructions to follow.
- You may care for and handle your baby as you wish at home including bathing and dressing, however over handling may increase the speed of the changes outlined

below. Therefore, ideally your baby should be kept in contact with the Cuddle Cot as much as possible.

- We would encourage you to contact your funeral director as soon as possible so that you can make arrangements to have your baby collected from home, when you feel the time is right. We would recommend that you contact a funeral director within 3 days of being discharged.

Possible Changes to Baby's Condition

We would like to let you know of the possible changes that may occur with your baby's appearance over the coming days and this is normal:

- Darkening of baby's lips and skin.
- Baby's skin may become fragile and sometimes start to slip.
- Sometimes you may notice some fluid leaking from baby's nose, mouth or skin.

Legal Responsibilities

It is important that you understand that it is your responsibility to register your baby's death within 42 days (stillbirth) 5 days (neonatal death). Taking your baby home should not delay this process.

The bereavement midwife/delivery suite midwives will advise you on how to do this.

If you choose to make funeral alternative arrangements, it is your responsibility to make sure that you are acting within the law. Please see The Environment Agency - Funeral practices, spreading ashes and caring for the environment: Meeting the needs of families and the environment. Available at: <https://docplayer.net/20771684-Meeting-the-needs-of-families-and-the-environment.html> (June 2021).

Changing your Mind

We recognise that circumstances and feelings change, and you may decide that having your baby at home is no longer the best thing for you as a family. If this happens the best place for the ongoing care of your baby is with the funeral director. Funeral directors will continue to allow you to visit your baby and support you as a family until the funeral. Please ensure that the cold cot is returned to the maternity unit after use. Alternatively, if you have been referred to Hope House you can contact them 24/7 for support.

Support and Useful Contact Details

- Hope House 24/7 Support (If you have been referred) - 01691 671999.
- Your chosen Funeral Director (some offer 24/7 support).
- Delivery Suite (for advice only) – 01952 565953
- Community Midwives (For collection of Cuddle Cot if applicable or advice) – 01952 565725/565726.
- Specialist Bereavement Midwives (For collection of Cuddle Cot if applicable or advice) – 01952 565953).

Appendix 6.3



Cuddle Cot Guide Set Up

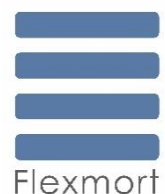
1. Place **silver insulation mat under** cooling pad (shiny side up) in moses basket/cot (Ensure the mat hoses are not twisted and fit through the holes in the basket if it has them) **cover with thin sheet.**
2. Plug unit in and place on a **stable surface** allowing space around unit during colling.
3. **Connect Hose** to unit and mat.
4. Open **Filler Cap** (blue cap) on top of the unit and put **2x drops** of the biocide into the unit.
5. Fill the unit with **sterile water** for irrigation, **slowly and carefully** fill to near the top of viewing window on side of unit. **Replace Filler Cap.**
6. Switch on unit by pressing on/off button on the top of the unit. The mat will fill.
7. Watch viewing window and **keep over half full throughout use.**
8. **Press 'c/f'** button on the top of unit to set temperature (**8°C/46°F**) press up/down arrow buttons to do this. Then press **Enter button** to confirm temperature set.

The unit can take up to 45 minutes to reach the temperature set!

1. Switch off unit (press on/off button) **DO NOT** unplug until the fan stops.
2. Disconnect mat from the hose by pressing **release clips.**
3. Clean mat with **sterile wipes**
4. Disconnect hose from unit by pressing button **under unit** and **gently** pulling hose.

Drain both hose and unit using drainage key. (insert key and press valves to empty water over sink.)

Ensure all equipment i.e unit with filler cap, both cooling mats, foils, Biocide, and drainage key are returned to the box prior to storage.



Taking Your Baby Home – Checklist for Staff
(Copy to be filed in patients notes)

Patient Details

Baby's Name:
DOB:
Hospital Number (if applicable):
Parents Names:
Address taken home to:

Agreed telephone number:
Date and Time of leaving the unit:

Documentation given to family:

- ☐ Copy of Stillbirth Certificate/Medical Certificate of cause of Death (if applicable).
- ☐ Funeral arrangements paperwork (copy to also be filed in notes).
- ☐ Taking Your Baby Home: Parents Letter.
- ☐ Taking Your Baby Home: Parent Information.
- ☐ Cuddle Cot Instructions (if applicable).
- ☐ Hope House leaflets (>22 weeks): "Counselling and Bereavement Support" and "When a Baby Dies".

Paperwork

- ☐ Taking Your Baby Home: Parents Letter given to parents and copy filed in patient notes.
- ☐ Taking Your Baby Home: Log completed (file in the Specimen Fridge folder).

Flexmort Cuddle Cot

- ☐ Given Flexmort Cuddle Cot
- ☐ Cuddle Cot Instructions given.
- ☐ Returning of equipment contact number given.

Name of Contact:

Community Midwives – Wrekin/Shrewsbury/Bridgnorth/Oswestry/Ludlow/Welshpool/Newtown.
Specialist Bereavement Midwives: 01952 565953
Parents to contact Hope House if Cuddle Cot Provided by them.

Have the following people been informed:

- ☐ Specialist Bereavement Midwives (ext 5953/email sath.bereavementmidwives@nhs.net).
- ☐ Community Midwives
- ☐ Health Visitor (Shropshire: shropcom.spoa@nhs.net/ T&W: shropcom.adminleonardst@nhs.net).
- ☐ GP (Midwife to GP handover directly).
- ☐ Hope House – if referral required 01691 671999.
- ☐ Mortuary (ext 4332/email sath.mortuaryprh@nhs.net).

Appendix 6.5

Taking Your Baby Home: Log

Baby's Name and Hospital Number (if applicable)	Mother's Name and Hospital Number	Address taken home to	Contact Number	Funeral Arrangements	Funeral Director (if known/applicable)	Name of staff member authorising release of baby to family and position.	Staff Signature	Date	Time



The Shrewsbury and Telford Hospital



NHS Trust

Parental Wishes Form

It is important that all sections of this form are completed in full to ensure we minimise the opportunity for causing additional distress to the parents. Do not hesitate to seek advice from your manager or from the Bereavement Midwives Ext 5953, PALS Advisor PRH Ext 4382 or the Mortuary Team PRH Ext 4332.

Part 1	Tick Appropriate Box	Enter Gestation
Aborted Fetus:- EFL/LFL/MTOP (under 24 weeks showing no signs of life)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Still Birth: (over 24 weeks gestation)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Neonatal Death: (showing signs of life at birth at any gestation)	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Part 2

Name of Baby/Fetus..... Date of Delivery.....

Date of Death..... (if neonatal) Mother's Hospital Number.....

Full Name of Mother..... Ward.....

Home Address.....

Postcode.....Religion.....

Mobile Number.....

Full Name of Father.....

Address (if different to mother's)
.....

Part 3 Please do not discard any personal items to be always kept with Baby

Is the baby dressed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Own blanket	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dressed in own clothes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hospital blanket	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dressed in hospital clothes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Does baby have Teddy Bear or other memorabilia	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Part 4Baby Post Mortem Birmingham
form

Yes

☐

No

☐

(If YES, Doctor/Bereavement Midwife to Complete PM

Part 5Baby's for Post Mortem
Transfer to Mortuary
firstHospital Transport
(Under 24 weeks.
Mortuary arrange
hospital transport)☐

Funeral Directors

☐(Over 24weeks – Notify PALS who will arrange
transfer to BWH by Funeral Director CJ Williams
Mon- Friday. Ext 4332 to arrange transfer by funeral
director)

PALS Office Ext 4382

(Transfers to Birmingham Women's Hospital are from Mortuary ONLY)**Part 6****One of the below forms must be completed and sent with baby to mortuary****Either** Hospital Cremation form <24weeks/Private
cremation form<24weeks/private cremation form for
Stillbirth or private cremation booklet for Neonatal death
(completed by Dr) only

Yes

☐

No

☐

Complete Burial Form (private burial only)

Yes

☐

No

☐**Please note sticky labels are not accepted by the Cemetery/Cremation Authorities****Part 7**

1.Do parents wish to make their own funeral arrangements?

Yes

☐

No

☐

(If YES – family will need to liaise with Funeral Director of their choice)

2.Are the parent's undecided – Bereavement Midwife will contact them within 7 days

Yes

☐

No

☐**Part 8**

Midwife's/Nurse Signature:

Print Name: Ward.....

FOR USE BY MORTUARY STAFF ONLY

Name of person who collected the remains:

.....

Signature:Print Name.....

***Please send this form for the attention of the PALS Advisor, PALS Office, PRH.**

The Shrewsbury and Telford Hospital



NHS Trust

Parental Wishes Form

It is important that all sections of this form are completed in full to ensure we minimise the opportunity for causing additional distress to the parents. Do not hesitate to seek advice from your manager or from the Bereavement Midwives Ext 5953, PALS Advisor PRH Ext 4382 or the Mortuary Team PRH Ext 4332.

Part 1	Tick Appropriate Box	Enter Gestation
Aborted Fetus:- EFL/LFL/MTOP (under 24 weeks showing no signs of life)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Still Birth: (over 24 weeks gestation)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Neonatal Death: (showing signs of life at birth at any gestation)	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Part 2

Name of Baby/Fetus..... Date of Delivery.....

Date of Death.....(If neonatal) Mother's Hospital Number.....

Full Name of Mother..... Ward.....

Home Address.....

Postcode.....Religion.....

Mobile Number.....

Full Name of Father.....

Address (if different to mother's)
.....

Part 3

Would the parents like an invitation to the Gathering of Remembrance which will be held twice a year in April and October.

Yes ☐ No ☐

If yes Email sath.bereavementmidwives@nhs.net with details of family.

Part 4

Baby Post Mortem Birmingham

Yes

☐

No

☐

(If YES, Doctor/Bereavement Midwife to Complete PM form)

Part 5

Baby's for Post Mortem

Transfer to Mortuary
first

Hospital Transport

(Under 24 weeks.
Mortuary arrange
hospital transport)☐

Funeral Directors

☐(Over 24weeks – Notify PALS who will arrange
transfer to BWH by Funeral Director CJ Williams
Mon- Friday. Ext 4332 to arrange transfer by funeral
director)

PALS Office Ext 4382

(Transfers to Birmingham Women's Hospital are from Mortuary ONLY)**Part 6****One of the below forms must be completed and sent with baby to mortuary****Either** Hospital Cremation form <24weeks/Private
cremation form<24weeks/private cremation form for
Stillbirth or private cremation booklet for Neonatal death
(completed by Dr) only

Yes

☐

No

☐

Complete Burial Form (private burial only)

Yes

☐

No

☐**Please note sticky labels are not accepted by the Cemetery/Cremation Authorities****Part 7**

1.Do parents wish to make their own funeral arrangements?

Yes

☐

No

☐

(If YES – family will need to liaise with Funeral Director of their choice)

2.Are the parent's undecided – Bereavement Midwife will contact them within 7 days

Yes

☐

No

☐**Part 8**

Midwife's/Nurse Signature:

Print Name:Ward.....

FOR USE BY MORTUARY STAFF ONLY

Name of person who collected the remains:

.....

Signature: Print Name.....

***Please send this form for the attention of the PALS Advisor, PALS Office, PRH.**

Standard Operating Procedure (SOP)

SOP Title	Cuddle Cot Set Up and Monitoring SOP		
SOP Number	016		
Care Group	Womens and Childrens Care Group		
Version Number	2		
Effective Date	September 2025	Review Date	
Author	Charlotte Tongue and Jan Latham		
Approved by	MGG and Maternity Clinical Governance Meeting		
Approval date	15 th September 2023		
Distribution	Delivery Suite		
Location	Maternity Services		

Document Control				
Version	Date	Author	Status	Comments
1.0	24 th January 2022	Bereavement Midwives	NEW	Cool cot is used to allow family additional time to be spent together to create memories.
2.0	15 th September 2023	Bereavement Midwives	Review	Full review of cuddle cot SOP and to combine archived SOP 'The Use of Cuddle Cot'.
3.0	September 2025	Bereavement Midwives	Full Review	

SOP Objectives	<ul style="list-style-type: none"> ❖ To ensure correct set up of cuddle cot in any setting e.g. delivery suite, mortuary. ❖ To ensure correct checking of cuddle cot.
Scope	Midwives, Nurses, Maternity Support Workers and Mortuary Staff.
Performance Measures	Monitored as part of the clinical audit and governance process.

Number	Brief	Responsibility
1	<p><u>Why and where the cuddle cot will be used.</u></p> <p>We have one chance to get it right, for every patient, every time. The Cuddle Cot is used to allow the family additional time to be spent together to create memories.</p> <p>Cuddle cot (Cold Cot) is a portable cooling system which is designed to keep a deceased baby or small infant cool, preserving condition and dignity after death. This allows families to keep their baby(ies) by their bedside from birth to the day of the mother's discharge home. The baby(ies) will then be transferred to the Mortuary. Parents may want to visit their baby after discharge from PRH Women and Children's Unit and this would take place in the Swan Bereavement Suite at PRH.</p> <p>The family will be informed that the baby will be nursed in a crib/cot in the Swan Bereavement Suite. Parents should be sensitively informed of the expected physical changes to their baby following death (i.e. colour changes, skin integrity and leakage of body fluids, odour). They should be reassured that these changes are expected and may be minimised by the use of the Cuddle Cot which allows parents/family members to spend as much time as required caring for their baby.</p> <p>The cold room within the Mortuary runs at 4 degrees Celsius. Due to the cold temperature, the families of the deceased baby (ies) may be unable to spend extended periods of time in the room. Therefore it is acceptable for the family to leave the cold room and then re-enter or the mortuary team can offer to set up the Cuddle cot which will allow the visit to take place in the adults visiting area. This will increase the comfort for the family/loved ones whilst still spending time with their deceased baby. However, the family members will be advised that use of the cuddle cot within the Swan Bereavement Suite is only available in working hours, 09:00 and 16:00.</p> <p>The (Cuddle Cots (cold cot) will be stored on Delivery Suite and can be collected by the mortuary staff member during the hours detailed above. The Cuddle Cot (cold cot) system will be set up, in line with the manufacturer's guideline, by the Bereavement midwife or a member of the mortuary team.</p>	All Staff

2	<p><u>Set Up of Cuddle Cot</u></p> <ol style="list-style-type: none"> 1) Place silver insulation mat under cooling pad (shiny side up) in moses basket/cot (Ensure the mat hoses are not twisted and fit through the holes in the basket if it has them) cover with thin sheet. 2) Plug unit in and place on a stable surface allowing space around unit during cooling. 3) Connect Hose to unit and mat. 4) Open Filler Cap (blue cap) on top of the unit and put 2x drops of the biocide into the unit. 5) Fill the unit with deionised water; slowly and carefully fill to near the top of viewing window on side of unit. Replace Filler Cap. 6) Switch on unit by pressing on/off button on the top of the unit. The mat will fill. 7) Watch viewing window and keep over half full throughout use. 8) Press 'c/f' button on the top of unit to set temperature (8°C/46°F) press up/down arrow buttons to do this. Then press Enter button to confirm temperature set. 9) The unit can take up to 45 minutes to reach recommended temperature of 8°C-13°C. Place the baby on the pad once the machine reaches these temperatures. 	Midwives, Nurses, Maternity Support Workers Mortuary Staff
3	<p><u>Monitoring Cuddle Cot</u></p> <ol style="list-style-type: none"> 1) Check and document temperature and that there is sufficient water in the tank every 3 hours. 2) Check the water level by the clear plastic chamber on the side of the machine, there should be a small gap at the top to ensure that the machine is not filled up to high (should be topped up between 1/3rd-2/3rds). 3) Use Cuddle Cot Checking Sheet (Appendix 3) to document each check and ensure it is labelled with patient information. 	Midwives, Nurses, Maternity Support Workers Mortuary Staff
4	<p><u>Information for Staff</u></p> <ol style="list-style-type: none"> 1) Refer to the Flexmort Cuddle Cot Cooling System Instruction Booklet found in each cuddle cot box (Appendix 1). 2) Refer to 4Louis Cuddle Cot Guide Set Up (Appendix 2). 	Midwives, Nurses, Maternity Support Workers Mortuary Staff
5	<p><u>After Use</u></p> <ol style="list-style-type: none"> 1) Switch off unit (press on/off button) DO NOT unplug until the fan stops. 2) Disconnect mat from the hose by pressing release clips. 3) Clean mat with sterile wipes 4) Disconnect hose from unit by pressing button under unit and gently pulling hose. 5) Drain both hose and unit using drainage key. (Insert key and press valves to empty water over sink.) 6) Ensure all equipment i.e. unit with filler cap, both cooling mats, foils, Biocide, and drainage key are returned to the box prior to storage. 	Midwives, Nurses, Maternity Support Workers Mortuary Staff

Packing Away the CuddleCot

1. Switch off the unit by pressing the power button but do not unplug until the fan stops operation.
2. Disconnect the cooling pad from the hose by pressing the release clips on the hose. Clean the pad according to hospital or your organisation's procedures.
3. Disconnect the hose from the unit by pressing down the plastic button on the underside of the control unit and gently pulling on the hose.
4. Drain the water from the unit by inserting the drain key under the fluid level hole. For long term storage (30 days+), also drain the hose by inserting the key into the hose.



General Maintenance and power cord warning

If dust builds up around the fan, remove the cover and wipe clean. Used cold pads should ideally be replaced every 12wths. If the supply cord is damaged, it must be replaced by Flexmatt, its service agent or similarly qualified persons, in order to avoid a hazard.



Warranty

The unit comes with a 12 months warranty which can be extended. Please contact Flexmatt at info@flexmatt.com. For spare parts please contact us at info@flexmatt.com



The Flexmatt CuddleCot cooling system quietly cools any size Moses basket, crib or cot, allowing parents to spend time with their precious baby.

Specifications

- Cooling unit 37cm x 23cm x 13cm. Weight 3.8kg
- Does not contain refrigerant
- 115-240V, 50/60Hz, 200W, operating temperature range 8°C-13°C (48-55°F)
- Fuse rating is 4A/750V 4Amp 20 x 5mm Fuse 4A F4AL 250V Chint B10
- UK/EU & AUS model Class 1
- US/CSA model Class 2



Accuracy House
2nd Floor, 55 Newbold Street
Birmingham B3 3JB
UK
Phone: +44 (0)8455 33351
Fax: +44 (0)8455 33352
Email: info@flexmatt.com



Flexmatt Medical Solutions

Instruction Booklet



Flexmatt Medical Solutions

www.flexmatt.com



Warning

The appliance is not intended for use by children or persons with reduced physical, sensory or mental capabilities or lack of knowledge, unless they have been given supervision or instruction by a person responsible for their safety.

Children should be supervised to ensure that they do not play with the appliance. The CuddleCot is for indoor use only, altitude up to 2000m, operating temp 5-25°C. Max relative humidity 80% at 23°C decreasing linearly to 50% at 25°C. Mains supply voltage fluctuations up to $\pm 10\%$ of the nominal voltage.

What's in the Box?

- CuddleCot™ cooling unit
- Two soft cool pads; 1 standard for full term & 1 small pad for premature
- 3' / 90cm Hose
- Foil coated insulation
- Small bottle of biocide
- Drain Key
- Instruction manual

There is a short video to assist with set up on the dedicated CuddleCot page at www.flexmory.com

Note

During storage purified water is left within the hose and cooling pad. The use of Flexmory's biocide neutralises bacteria and algae which could accumulate.

Using the CuddleCot system

1. To improve cooling efficiency, place the silver insulation under the cooling pad. Use double thickness and face the silver side upwards.
2. Place the cooling pad and insulation in the basket on top of the mattress (if present). Ensure the two hoses which lead from the pad are exposed and pushed through the basket. A thin sheet can be used to cover the cooling pad.

3. Remove the unit from the box, plug into the electrical socket.



4. Plug the cooling pad connectors into the end of the hose. Again there should be a "click".



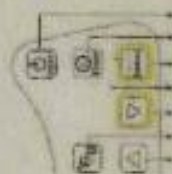
5. Plug the hose containing the large plastic connector into the cooling unit. You should hear a "click".



6. Open the filler cap and place a couple of drops of biocide into the unit. Fill the cooling unit with purified water until the water level is near the top of the viewing window.

7. Switch on the cooling unit by pressing the on/off button. The cooling pad will start to fill and the water level will drop. Ensure there are no leaks in the hose or pad else fluid will not circulate. Continue to fill the unit with purified water until the tank remains over half full [the cooling pad will now be full of water]. Always keep the unit topped up between $\frac{1}{2}$ to $\frac{3}{4}$ during operation. An alarm will sound should the water level drop too low.

8. Select temperature display [°C or °F] by pressing the °C/°F button on the unit. The display will show the temperature of the water in the cooling unit. Set the required temperature to the lowest setting on the control unit (i.e. 8°C or 46°F). To do this, press and hold the down arrow key until



8 (or 46) is displayed, then press "Enter". The unit will begin to cool the cooling pad. When the pad starts to feel cool, place the baby on the pad. Within approximately 45 mins the display on the unit will reach between 8°C-13°C (46-55°F) depending on ambient conditions. These are normal operating temperatures and the cooling pad will feel cold.

9. Cover the baby with blankets as this will act as insulation. For longer term use (e.g. through the night), the baby can be fully covered with blankets (including the head).



10. Always ensure at least 15cm / 6" space remains around the unit during cooling.

N.B. only use purified water i.e. distilled, de-ionised or sterilised

Troubleshooting

- The unit is beeping and a blue display appears on the display
the unit is low on water, see 7
- The cooling pad is warm and not cooling
1. Ensure there are no leaks and the unit is set at 8°C/46°F
2. There may be trapped air in the cooling pad. To remove, leave unit running and loosen the filler cap and roll the pad (like rolling a napkin) towards the hose inlet/outlet to remove the air.
SEE VIDEO AT WWW.FLEXMORY.COM/SERVICE
- The unit turns off after 20/30 minutes.

The system has a timer which may have been activated. To ensure the timer is off, press the Timer button until "0" is displayed. Continuous cooling is recommended.



Cuddle Cot Guide Set Up

9. Place **silver insulation mat under** cooling pad (shiny side up) in moses basket/cot (Ensure the mat hoses are not twisted and fit through the holes in the basket if it has them) **cover with thin sheet.**
10. Plug unit in and place on a **stable surface** allowing space around unit during colling.
11. **Connect Hose** to unit and mat.
12. Open **Filler Cap** (blue cap) on top of the unit and put **2x drops** of the biocide into the unit.
13. Fill the unit with **sterile water** for irrigation, **slowly and carefully** fill to near the top of viewing window on side of unit. **Replace Filler Cap.**
14. Switch on unit by pressing on/off button on the top of the unit. The mat will fill.
15. Watch viewing window and **keep over half full throughout use.**
16. **Press 'c/f'** button on the top of unit to set temperature (**8°C/46°F**) press up/down arrow buttons to do this. Then press **Enter button** to confirm temperature set.

The unit can take up to 45 minutes to reach the temperature set!

5. Switch off unit (press on/off button) **DO NOT** unplug until the fan stops.
6. Disconnect mat from the hose by pressing **release clips.**
7. Clean mat with **sterile wipes**
8. Disconnect hose from unit by pressing button **under unit** and **gently** pulling hose.

Drain both hose and unit using drainage key. (insert key and press valves to empty water over sink.)

Ensure all equipment i.e unit with filler cap, both cooling mats, foils, Biocide, and drainage key are returned to the box prior to storage.



Patient Sticker/Identification

[illegible]

- ❖ Cuddle Cot takes 45 minutes to get to the recommended temperature of 8c-13c. Place the baby on the pad once the machine reaches these temperatures.
- ❖ Check and document temperature and that there is sufficient water in the tank every 3 hours.
- ❖ Check the water level by the clear plastic chamber on the side of the machine, there should be a small gap at the top to ensure that the machine is not filled up to high (should be topped up between 1/3rd-2/3rs).
- ❖ Write any actions/comments e.g. adjusted temperature or topped up water level.

Appendix 9

Standard Operating Procedure (SOP)

SOP Title	Perinatal Deaths - MBRRACE reporting		
SOP Number	096		
Care Group	Women and Children's		
Version Number	2		
Effective Date	11 th April 2025	Review Date	April 2028
Author	Specialists Midwives (Bereavement)		
Approved by	Maternity Governance, Neonatal Governance		
Approval date	11 th April 2025		
Distribution	All maternity and Neonatal staff		
Location	Maternity		

Document Control				
Version	Date	Author	Status	Comments
1	22 nd October 2020	Jan Latham, Elizabeth Pearson and Jacqui Bolton	New	New SOP this version
1.1	14 th April 2022	Jan Latham	Update	MBRRACE reporting times in line with CNST year 4.
1.2	27 th June 2023	Michelle Powell, Charlotte Tongue	Update	Update
2	11 th April 2025	Michelle Powell/Charlotte Jackson	Full review	

SOP Objectives	Process to comply with NHS Resolution Maternity incentive scheme safety action 1 required all perinatal deaths eligible to be notified to Mothers and Babies; Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK) from 6 th May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.
Scope	This SOP is to clarify the process for reporting cases to MBRRACE-UK within the set timeframe
References	NHS resolutions CNST Year 7: MIS-Year-7-guidance.pdf

Performance Measures	SOP being monitored by Specialist Midwives (Bereavement)
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Number	Brief	Responsibility
1	<p>In this SOP we use the terms ‘woman’ or ‘mother’ throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth.</p> <p>Criteria for reporting deaths to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK)</p> <ul style="list-style-type: none"> • Late fetal losses – the baby is born at 22 or 23 completed weeks' gestation showing no signs of life, irrespective of when the death occurred. • Stillbirths – the baby is born from 24 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred. • Neonatal deaths – the death of a live born baby born from 20 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) occurring before 28 completed days after birth. <p>The eligibility criteria for notification to MBRRACE-UK is based on the baby's gestational age at birth. This means that babies born from 22 completed weeks' gestational age showing no signs of life must be reported to MBRRACE-UK regardless of when the death occurred.</p> <p>Terminations of pregnancy resulting in a registered stillbirth (from 24 completed weeks' gestation) or neonatal death (from 20 completed weeks' gestation) should also be notified to MBRRACE-UK. Information about terminations of pregnancy is collected in order to exclude these cases from MBRRACE-UK reported statistics on perinatal mortality.</p> <p>Section 2</p> <p>Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?</p> <ol style="list-style-type: none"> a) Notify all deaths: All eligible perinatal deaths should be notified to MBRRACE UK within seven working days. b) Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards. c) Review the death and complete the review: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 2 April 2024; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months. 	

	d) Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	
2	<p>Time limit for notifying a perinatal death</p> <p>Safety Action 1 requires all perinatal deaths eligible to be reported to MBRRACE-UK from 6th May 2022 onwards must be notified to MBRRACE-UK within seven working days.</p> <p>Following notification within seven days the surveillance form, where required, must be completed within one month of the death. If at that stage post-mortem or other investigations are not available, indicate this in the "Cause of Death/Confirmation of cause of death" section, complete the rest of the information, and close the surveillance form. Once the additional information is available the reporter should re-open the case, update the relevant sections and close it again.</p>	Specialist Midwife (Bereavement) Or Deputy
3	<p>Statutory Obligation</p> <p>The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. This includes the notification to MBRRACE-UK of neonatal deaths within 7 working days of the baby's death.</p>	Specialist Midwife (Bereavement) Or Deputy
4	<p>Process for reporting</p> <p>Datix to be raised by the clinician (Obstetrician, Neonatologist, Midwife or Nurse) in the specialist area: -</p> <ul style="list-style-type: none"> • Delivery Suite- Midwife/Co-ordinator • Neonatal Unit-Neonatologist or Neonatal nurse • Antenatal Ward/Triage/Postnatal Ward- Midwife <p>To ensure that all perinatal deaths are reported to MBRRACE within the 7 working day timeframe the clinical area must contact the Specialist Midwife (Bereavement) and inform them of the death. This must be done on the same day that the death has occurred or next working day if over a weekend or public holiday.</p> <p>The Specialist Midwife (Bereavement) must confirm the reporting of each case to the Director of Midwifery (DOM) and Deputy Directors of Midwifery (DDOM).</p> <p>If Specialist Midwives are unavailable due to annual leave/sick leave/special leave the Divisional Quality Governance Lead- Women and Childrens and Quality Governance Team must be contacted within the same timeframe, and they will then be responsible for reporting the death to MBRRACE.</p>	<p>Obstetrician, Neonatologist or Midwife</p> <p>Specialist Midwife (Bereavement)</p> <p>Specialist Midwife (Bereavement)</p> <p>Quality Governance Team- Women and Children's</p>

5	<p>How will this be monitored</p> <ul style="list-style-type: none"> Trust submissions will be subject to a range of external verification points, these include cross checking with: MBRRACE-UK data (safety action 1 point a, b, c) <p>Individual cases reported to MBRRACE are given a unique reference number, this indicates the date of reporting the case.</p>	
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Appendix 10

Standard Operating Procedure (SOP)

SOP Title	Post Mortem Consent Perinatal Pathology Service facilitated by Birmingham Women's Hospital (BWH)		
SOP Number	095		
Care Group	Women and Children's		
Version Number	2		
Effective Date	September 2025	Review Date	
Author	Bereavement Midwife and Guideline Midwife		
Approved by	Maternity Guideline Group, Maternity Governance, Neonatal Governance		
Approval date			
Distribution	All maternity, EPAS and Neonatal staff		
Location	Maternity		

Document Control				
Version	Date	Author	Status	Comments
1	22 nd October 2020	Jan Latham and Jacqui Bolton	New	Perinatal pathology service provision from BWH
2	15 th September 2023	Charlotte Tongue and Michelle Powell	Review	Full Review
3	September 2025	Charlotte Jackson and Michelle Powell	Full Review	

SOP Objectives	<ul style="list-style-type: none"> To provide staff with an update to the service provision for post mortem examination at Birmingham Women's Hospital (BWH) and Alder Hey. To comply with the BWH and Alder Hey Pathology service provision To provide families with appropriate patient information as supplied by BWH Pathology Service.
Scope	Also refer to Placenta SOP
Performance Measures	Monitored as part of the clinical audit and governance process ACE reporting (096) v2 April

Number	Brief	Responsibility
1	<p>Introduction</p> <p>Due to the national shortage of perinatal pathologists and the ongoing limited availability of perinatal pathologists currently within Birmingham Women's Hospital Mortuary Service, who were previously providing our perinatal post mortem service, it became necessary to have a temporary change to the service. From the 1st December 2022 mutual aid has been provided by several Perinatal Pathology Centres in supporting the perinatal post mortem service. Placenta's going for placenta histology will continue to be taken by hospital transport to Birmingham Women's Hospital as usual and staff should continue to use the Birmingham Women's Hospital Clinical History Summary Sheet for Non-Consent Placental Histology when sending the placenta's.</p>	
2	<p>Post Mortem NHS England Criteria</p> <p>NHS England will commission perinatal pathological examination in line with the following criteria:</p> <p>Inclusion Criteria</p> <ul style="list-style-type: none"> • All fetus' 11-24 weeks (See workflow guidance Appendix 1 for approach to macerated vs. unmacerated) • Stillbirth from any cause > 24 weeks gestation • Fetal anomaly without a unifying diagnosis (including suspected skeletal dysplasia) • Referral from specialist fetal medicine team • Intra partum death (if not referred to HM Coroner) • Neonatal death (if not referred to HM Coroner) <p>Exclusion Criteria</p> <ul style="list-style-type: none"> • Fetal gestation < 11 weeks • Clinically documented abruption at delivery, where no other issues are raised • All antenatally diagnosed aneuploidy (e.g., Known T13/18/21 monosomy X/22q deletion) • Uncomplicated anomaly where the unifying clinical diagnosis has been definitively determined (e.g., uncomplicated neural tube defect) and post-mortem examination is unlikely to yield any further useful information • Cases where the only clinical question is determination of gender • Cases which require cytogenetic sampling only <p>NHS England » Perinatal post-mortem investigation of fetal and neonatal deaths (England, Scotland and Wales)</p>	Post Mortem Consent Taker

3	<p>Post Mortem Consent</p> <p>It has been agreed with mutual aid trusts that post mortem consent takers can still use the Birmingham Women's Hospital Perinatal Post Mortem Consent form. As usual, detailed written consent for post-mortem examination is required from a parent, preferably the mother, regardless of gestation. Consent must be taken by a doctor or midwife who has received the relevant training. Consent must be recorded on the approved document. Prior to obtaining consent, parents will be given time to read the patient information leaflets on post-mortem examinations and ask questions. The yellow part of the post-mortem consent form is given to the parents, blue part filed in the medical notes and grey part is sent with the baby for post mortem.</p>	Post Mortem Consent Taker
4	<p>Clinical History Summary Sheet</p> <p>Complete the Alder Hey Hospital Clinical History Sheet for all babies going for post mortem. These can be found in all bereavement paperwork packs regardless of type of loss. As usual, all USS reports should be attached, and an addressed envelope will be included. Both the clinical summary sheet and grey copy of the post mortem consent should go in the Alder Hey addressed envelope and will be transported with baby to Alder Hey.</p>	Post Mortem Consent Taker
5	<p>Process</p> <ol style="list-style-type: none"> 1.) Post mortem consent obtained from family and paperwork completed. Consent form to be scanned and sent to BWH ahead of transfer and inform hospital mortuary. 2.) Once family discharged from delivery suite/neonatal unit baby should, if not done so already, be placed in a white mortuary cardboard box. Baby should have two labels with mother's details including address. Baby should also have 2 death cards, one inside the box and one on top of the box. Baby can have any clothing, blankets or teddies kept with them as requested by the family. 3.) The box containing baby should be placed in a clear plastic bag and placed in the cool storage unit on delivery suite and the relevant register/log should be completed which are kept in the drawers next to the cool storage unit. 4.) The placenta should always, if possible, be sent with baby in a separate white container. 5.) At 02:00 porters will make contact with delivery suite and transport baby from Delivery Suite to the Mortuary department after signing the relevant specimen fridge storage log paperwork. 6.) The baby will remain in the Mortuary until the Funeral Directors (for registerable births) or Hospital Transport (for non-registerable births) to collect baby. 7.) The Specialist Midwives (Bereavement) will contact Birmingham Women's Hospital Mortuary as this is where baby will be transferred to as a central point for the region before being transferred to Alder Hey. Once BWH Mortuary have accepted, baby can then be transferred to them. 8.) Following off site examination baby will be transported to BWH before coming back to PRH. 	Specialist Midwives (Bereavement), Delivery Suite Staff, Mortuary Staff.

6	<p>Infection risk babies</p> <ol style="list-style-type: none"> 1.) All Trusts MUST notify BWH mortuary of all the cases they are sending for examination where there is suspected or known infection risk babies. 2.) All high-risk babies can be dressed and wrapped to parents' wishes however MUST be sent to the mortuary in a body bag. They MUST be clearly labelled with the wording 'HIGH RISK' and the body bag decontaminated before sending. They must also be labelled with 3 points of ID e.g. name, hospital number and DOB. 3.) Documentation MUST be placed in an envelope and not inside the body bag and paperwork must clearly state type of infection risk. 4.) 	<p>Specialist Midwives (Bereavement), Delivery Suite Staff, Mortuary Staff.</p>
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Standard Operating Procedure (SOP)

SOP Title	Transfers from delivery suite cool storage to the mortuary		
SOP Number	056		
Care Group	Women and Children's		
Version Number	2.1		
Effective Date	September 2025	Review Date	
Author	Bereavement Midwives		
Approved by	Maternity Guideline Group and Maternity Governance		
Approval date	September 2025		
Distribution	All maternity areas		
Location	Maternity services		

Document Control				
Version	Date	Author	Status	Comments
1	16 th March 2018	Jan Latham & Jacqui Bolton	New	SOP describes the existing process of transfers between delivery suite cool storage and the mortuary
2	19 th May 2023	Charlotte Tongue and Michelle Powell	Review	Full review of SOP
2.1	15 th September 2023	Charlotte Tongue & Michelle Powell	update	
3	September 2025	Charlotte Jackson and Michelle Powell	Full Review	

SOP Objectives	<ul style="list-style-type: none"> ▪ To provide a standard procedure to ensure compliance with the Human Tissue Act (2004). ▪ To provide a standard procedure for staff that observes good practice as set out by the Human Tissue Authority (HTA) code of practice. ▪ To provide a standard procedure for staff to ensure that bodies of the deceased and tissue taken from them are treated with respect and dignity. ▪ To provide a standard procedure for staff on the transfer, security and storage arrangements between maternity and the mortuary including transfer to other institutions. ▪ To share information where appropriate and when requested by parents and or the family of the transfer, security and storage arrangements. ▪ To provide a standard procedure to ensure the records of bodies or tissue from the deceased comply with HTA.
Scope	<p>Relates to the handling of babies' remains and tissues for losses at all gestations and staff who provide care for or have contact with parents and or families during fetal loss, stillbirth or neonatal death.</p> <p>Also refer to Placenta SOP</p>
Performance Measures	Monitored as part of the clinical audit and governance process.

Number	Brief	Responsibility
1	<p>In this SOP we use the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth.</p> <p>The Human Tissue Act 2004 and the Human Tissue Authority (HTA) Codes of practice and Licensing Standards govern how the bodies and remains of babies are handled and stored by SaTH.</p>	
2	<p>Once parents plan to leave the maternity unit the baby will be transferred to the mortuary from the cool storage unit on delivery suite. If parents are taking their baby/babies home, please refer to Fetal Loss and Early Neonatal Death Guideline</p> <p>Discussion and consent with the parents prior to transfer including assuring the parents that their baby will be treated with respect and dignity at all times.</p> <p>Staff should wherever, possible accommodate parents' preferences in relation to the care of their baby/babies for example parents may wish to take their baby to the mortuary accompanied by a midwife and porter (National Bereavement Care Pathway Standards 2018)</p>	Midwife
3	The baby or remains are appropriately labelled as detailed in the Fetal Loss and Early Neonatal Death Guideline.	Midwife

4	<p>Cool storage unit on delivery suite</p> <p>Transfers to the cool storage unit may come from the neonatal unit, delivery suite, bereavement room on the antenatal ward and the Early Pregnancy Assessment Service (EPAS)</p> <p>The unit is kept locked at all times the key is located in the secure key store unit.</p> <p>A pharmacy temperature log book is completed daily and includes instruction/escalation on temperature discrepancies.</p>	Delivery suite staff
5	<p>Records</p> <p>A separate folder is allocated to and includes record sheets dependent on the type of transfer being arranged this will include documents of transfers between delivery suite to the mortuary and to Birmingham Women's Hospital (BWH) via hospital transport.</p> <p>The folders are located in the locked point of care testing room.</p> <p>Information entered</p> <ol style="list-style-type: none"> 1. Date placed into cool storage unit 2. Mothers name and unit number 3. Placenta only for BWH can be transported by hospital transport direct from delivery suite and are not required to be sent via the mortuary– Refer to Placenta SOP. 4. A baby or fetus that is being transported to BWH is required to transfer from delivery suite via the mortuary and will include the placenta. 5. A baby or fetus is required to transfer from delivery suite to the mortuary if parents have declined post mortem/further investigations. 6. Paperwork complete to include Parental Wishes form, burial/cremation form, post mortem consent (with clinical summary) 7. Mothers identification stickers x 2 in the folder for the Porter 8. Midwife's signature 9. Date transfer from delivery suite has taken place <p>The record sheets are signed by the midwife and porter/mortuary or courier dependent transfer requirements.</p>	Midwife and Porter

7	<p>Communication and documentation</p> <p>The porter makes contact with delivery suite at 02.00 to organise any transport requirements.</p> <p>When attending delivery suite the midwife will hand over the baby, fetus or placenta to the porter. Placenta only for BWH can be transported by hospital transport direct from delivery suite and are not required to be sent via the mortuary. Refer to Placenta SOP.</p> <p>Both porter and midwife complete the checklist and sign the relevant record sheet.</p> <p>The porter is provided with 2 identification stickers with the mother's details which are used for entering into the mortuary register to identify the baby or fetus.</p>	Midwife and Porter
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Zipporah Registrars Booking System **Document Upload** **For Medical Practitioners**

This manual explains how to use the document upload function of the Registrars Zipporah diary management system

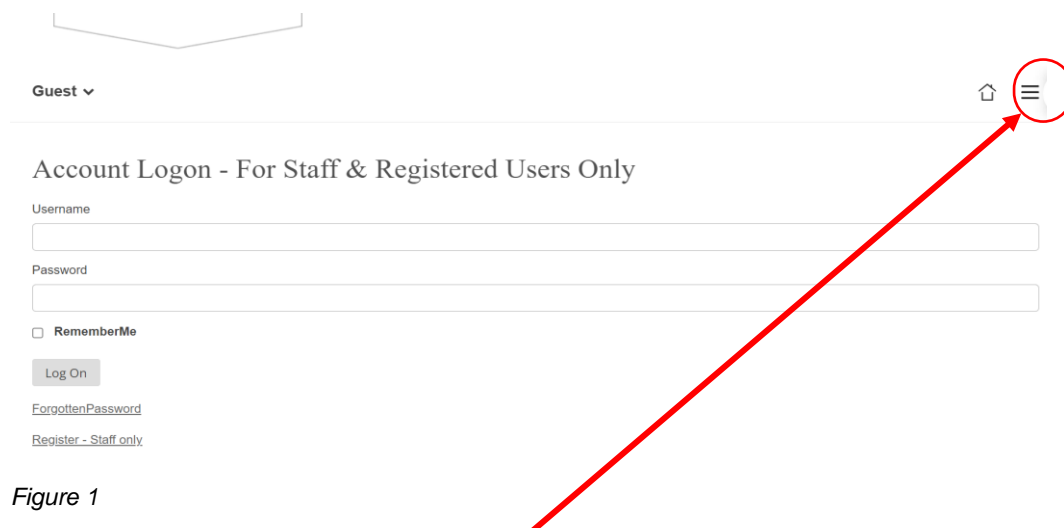
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Access to Zipporah

The Registration Service uses an electronic booking system for all registrations called Zipporah. Members of the public have access to the system to book appointments online. A function to scan documents to the system has now been added.

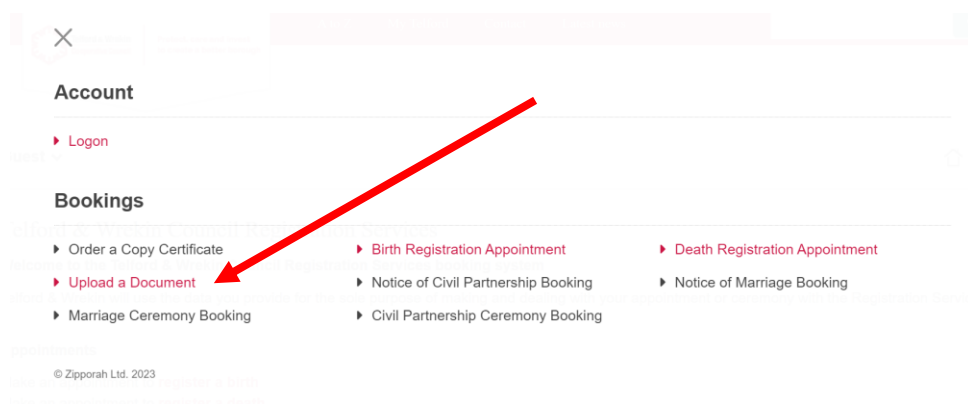
Website: [Telford & Wrekin Council Registration Services \(zipporah.co.uk\)](http://zipporah.co.uk)



Click the Menu Icon in the top right of the screen.

Uploading a Document for Death Registrations

To upload a document, click here and select **“Upload Document”**



... this will open the document upload portal. To upload a document for a death registration, select the appropriate button.

Guest ▾

Document Upload Portal

Please select the relevant appointment type and complete all information below before uploading your document(s)

Select the relevant appointment type

☐ Birth ☒ Death ☐ Marriage

Please provide the following information and then select the document(s) you need to upload

If you are adding documents to your appointment please complete the booking ID and name section only. If you are a Hospital/Doctor/Coroner please provide all detailed EXCEPT the booking ID.

Booking ID

Figure 3

This process will be the one that Doctor's, Coroners and GP's follow.

It allows the relevant party to upload a document on to the system **PRE-appointment**.

This will then trigger a process which firstly allows Registrars to check the documents, and then once accepted, prompts the customer to make a death registration booking on the website. The documents will then automatically be attached to that booking, and the customer won't need to do anything more.

Step 1: DON'T fill in the Booking I.D here, as it doesn't exist yet! It will be created later.

Step 2: Fill out all the remaining fields. This information will be captured to save the customer time when they make the booking.

Step 3: Upload the document(s) by clicking Choose Files and selecting the relevant docs.

Step 4: Submit

(Example form on next page)

Your contact email – is the surgery, hospice, coroner, hospital email

Informant email – is for the NOK or informant, or someone in the family that has an email so that the booking can be made.

Please provide the following information and then select the document(s) you need to upload

Only enter "Booking ID" if an appointment has already been made

Booking Id

Deceased First Name

Deceased Surname

Your Contact Email

Informant First Name

Informant Surname

Informant Telephone

Informant Email

Upload Document(s)

No file chosen

Figure 4

It is important that all information is entered here so there are adequate contact details should registrars need to contact the GP/Doctor about the scanned documents, and to allow registrars to contact the informant.

Reviewing the uploaded Death Documents

Now the documents have been submitted, Registrars will review them before inviting the customer to make an appointment to Register.

What if the Registrar has an issue with the scanned document?

If the document is reviewed and needs something adding/amending, it can be marked as such by the Registrar. This will trigger an email to the address entered in the GP/Doctor's Email Address field during the document upload process. The email will inform the recipient that the document needs amending or something needs clarifying.

What happens next?

This triggers an email to the Informant, inviting them to make a death registration booking.

The email contains a hyperlink which will take them directly to the booking process. This ensures that the booking they make will be linked to the document(s)

The system will also auto-fill information in the booking process based on what the GP/Doctor entered when uploading the documents.

Once the appointment is booked, the documents will automatically apply to it and can be viewed by Registrars during the appointment.