Sherwood Forest Hospitals
NHS Foundation Trust

REPORTING OF PERINATAL DEATHS PROCEDURE

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Scope/ Target Audience: (delete as applicable / describe)	**Specialty/ Department** (for the minority) • **Staff** – Midwives, Obstetricians, Pediatrician's, Neonatal Nursing Staff, Child Death Review Team • **Patients** – newborn infants • **Clinical areas** – Sherwood Birthing Unit, Neonatal Unit

Evidence Base/ References:	See Section 5

Lead Division:	Women & Children's
Lead Specialty:	Paediatrics (Neonatal)
Lead Author:	Jackie Briggs - Specialist Nurse for the Child Death Review Team
Other Contributors	Louise Heath - Bereavement Midwife
Sponsor:	W&C Divisional CG Lead

	Name the documents here or record not applicable
Associated Policy	N/A
Associated Guideline(s)	N/A
Associated Pathway(s)	N/A
Associated Standard Operating Procedure(s)	N/A
Other associated documents e.g. documentation/ forms	N/A

Consultation Undertaken:	• Circulated across Paediatrics/ Neonates as well as obstetrics/ Maternity • ME and ME Officer have sighted the documents also.

Template control:	v1.4 November 2019

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1.0 INTRODUCTION/ BACKGROUND

This procedure has been written to support Midwives, Obstetricians, Paediatricians and Neonatal Nursing Staff in the management of perinatal death (stillbirths and deaths in the first week of life; World Health Organisation (WHO) 1992). This protocol includes preterm infants and non-viable fetuses who are born alive and any infant whose death occurs during birthing (intrapartum stillbirth) or immediately afterwards.
It does not include intrauterine fetal death diagnosed before labour commenced.

This procedure describes the management of infants who die during birthing or soon after, usually in the Birthing Unit. Deaths of infants who are successfully resuscitated and subsequently die on the neonatal unit will be managed as per neonatal guidelines, but principles of notification and investigation will be similar.

2.0 DEFINITIONS AND/ OR ABBREVIATIONS

'Live birth'

WHO 1992 ICD 10 definition of 'live birth' is accepted in the UK for the purposes of registration and has been refined by Confidential Enquiries into Stillbirths and Deaths in Infancy (CESDI) to state as follows:

A live birth has occurred when, 'complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which after separation, breathes or shows evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movements of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered 'live born' (WHO, 1992)

Detectable pulsation as a result of cardiac massage is not a valid sign and that a respiratory gasp has to be spontaneous and active, rather than as a result of resuscitation attempts in order to be considered a valid sign of life.
(CESDI, 1996)

'Stillbirth of 24 weeks gestation and above'

Any child expelled or issued forth from its mother after the 24th week of pregnancy that did not breathe or show any other signs of life should be registered as a stillbirth
(Stillbirth Definition Act 1992)

'Perinatal death'

Death of an infant born after 24 completed weeks of gestation whose death occurs before 7 completed days.

'Early neonatal death'

Death of an infant from birth to 7 days regardless of gestation

'Late neonatal death'

Death of an infant from 7 days to 28 days regardless of gestation

3.0 PROCEDURE DETAILS (Including flowcharts)

Actions

1) All perinatal deaths (excluding intrauterine foetal death diagnosed before labour commences) are subject to statutory notification.
2) All perinatal deaths need to be discussed with the Medical Examiner (ME) Contact via the Bereavement Office (ext 4189).

The Medical Examiner will review the records and ask if any concerns relating to care.

If death occurs out of hours, a retrospective discussion with the Medical Examiner should take place with the ME the next working day with an update provided to the Child Death Review Team.

Out of hour's decisions in respect to Coronial referral should be made in conjunction with the consultant involved and the relevant documentation completed.

Flow Chart: Child Death Notification / Coroners Referral with Medical Examiner Discussion

Child Death Flowchart & Notification Form

3) The child death notification form should be completed and submitted within one working day and the discussion documented within health records
4) The criteria for cases requiring a Coroners referral should be considered and where this applies a referral to HM Coroner will be required but a discussion with the Medical Examiner must take place before submission.
5) If none of the above criteria applies the Medical Examiner may support the decision for a medical cause of death to be issued as per your proposed cause of death
6) A death certificate cannot be issued until agreement from the Medical Examiner or HM Coroner is given.

7) If a **CORONER'S REFERRAL IS required,** please send the notification to the coroner with a copy to the Child Death Review Team, the Bereavement Team and a copy for health records.

Send to	**è**	**coroners.office@nottinghamcity.gov.uk**
cc Child Death Review Team	**è**	**sfh-tr.ChildDeath@nhs.net**
cc Bereavement Team	**è**	**sfh-tr.bereavementcentre@nhs.net**

A Coroner's Officer will review email and respond, Monday – Friday in working hours

For URGENT discussion with HM Coroner please phone: 0115 841 5553
This should only be in exceptional circumstances where an urgent response is required from the coroner.

Examples:

a) **Discussion about organ donation** - If organ donation is being considered then a discussion with the Medical Examiner should take place, prior to proceeding. The Medical Examiner will provide pre-scrutiny and contact the Coroners' Office as required in cases where referral criteria are met.

b) **Where body needs to be released on religious grounds**

8) If a **CORONER'S REFERRAL is NOT required,** please send the notification to the Child Death Review Team, the Bereavement Team and a copy for Health records

Send to:		
Child Death Review Team	**è**	**sfh-tr.ChildDeath@nhs.net**
cc Bereavement Team	**è**	**sfh-tr.bereavementcentre@nhs.net**

The Consultant Obstetrician and Paediatrician may not always be present at the time of death. However, it is appropriate to ask them to attend soon after death to support family and staff. **All** cases should be discussed with the Consultant Obstetrician and Paediatrician regardless.

It is essential for the senior members of the team attending delivery and resuscitation to meet as soon possible after attempts at resuscitation have ceased, to discuss the death.

Where there are signs of life, regardless of gestation a notification form must be completed.

The following should be discussed and agreed actions allocated and recorded:

a) Who will complete Child Death Notification and have the discussion with the Medical Examiner
b) Proposed cause of death if known
c) What explanation will be given to parents and by whom?
d) All perinatal deaths should trigger a datix incident form which will activate the appropriate level of internal investigation and consideration for HSIB .
e) All Perinatal deaths which may be related to HIE or brain injury should be notified to the legal team within 48hrs.

2) Following discussion with the Medical Examiner there are 2 possible outcomes:

a) Issue a certificate as proposed
Cause of death agreed with the Medical Examiner (ME): Senior Paediatric / Obstetric staff to complete birth and death certificate as agreed with ME. Hospital postmortem may still be offered. Follow stillbirth / intrauterine fetal death policy (see below)

b) Do not issue – Referral to HM Coroner

3) Following referral to HM Coroner there are 2 possible outcomes:

a. Issue a certificate as proposed
Cause of death agreed with HM Coroner

b. Do not issue – HM Coroner will take the case
follow directions of the coroner.
Coronial postmortem if required will be arranged.

NB. The Coroners Documentation, to release an infant's body for burial / cremation, will only be signed by the coroner following agreed death certification or when Coronial enquiries are complete.

4) All deaths should be recorded on CareFlow.

5) Staff should complete the appropriate checklist regarding the care of mother and baby, this can be found within the guideline below.

Please refer to the guideline *'Management of Stillbirth, Intrauterine Fetal Death and Termination of Pregnancy for Fetal Abnormality'*, which can be found within the foetal loss section of the Maternity guidelines on the of the Trust Intranet.

4.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Statutory guidance, Working Together to Safeguard Children 2018 and responsibility for the child death review process transferred from the Local Safeguarding Children Board to the 'Child Death Review Partners' in 2019. Child death review partners,' consist of the local authority and clinical commissioning groups operating in the local authority area as set out in the Children Act 2004 (the Act), and as amended by the Children and Social Work Act 2017

Documentation and review of all Nottinghamshire and Nottingham City infant and child deaths is undertaken by the child death review team on behalf of the Child Death

Overview Panel, (CDOP) a subcommittee which reports to the Child Death Review Partners. Reviews are monitored against the additional detailed operational guidance in the form of 'Child Death Review: Statutory and Operational Guidance (England)' published by the Department of Health in October 2018.

The introduction of a 'Medical Examiner' role (2019) provided independent medical scrutiny of all non-coronial deaths.

All perinatal deaths are routinely reviewed in the perinatal morbidity and Mortality Meetings with external overview by the Trent Perinatal Network.

Compliance with policy can be monitored through these mechanisms and are reported to the Paediatric and Obstetric Clinical Governance Groups.

5.0 EVIDENCE BASE/ REFERENCES

- CESDI Secretariat. (1996) CESDI Definitions, Maternal and Child Health Research Consortium, London.
- WHO (1992) International Statistical Classification of Diseases and Related Health Problems Tenth Revision. Geneva: WHO, 1992;**1**;1235, para 3.1.
- Still-birth (definition) Act 1992 www.legislation.gov.uk/ukpga/1992/29/contents
- Working Together to Safeguard Children (2018) Department for Children Schools and Families
- Each Baby Counts (2021) Royal College of Obstetricians and Gynecologists
- Child Death Review: Statutory and Operational Guidance (England)' Department of Health 2018.

6.0 EQUALITY IMPACT ASSESMENT (EIA)

- Guidance on how to complete an EIA
- Sample completed form

Name of service/policy/procedure being reviewed: Reporting of Perinatal Deaths Procedure			
New or existing service/policy/procedure: Existing			
Date of Assessment: December 2022			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	N/A	N/A
Gender:	None	N/A	N/A
Age:	Neonates only	N/A	N/A
Religion:	None	N/A	N/A
Disability:	None	N/A	N/A
Sexuality:	None	N/A	N/A
Pregnancy and Maternity:	N/A	N/A	N/A
Gender Reassignment:	N/A	N/A	N/A
Marriage and Civil Partnership:	None	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	N/A	N/A

What consultation with protected characteristic groups including patient groups have you carried out? N/A
What data or information did you use in support of this EqIA? N/A
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? N/A

Level of impact

From the information provided above and following EqIA guidance document, please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Jennifer Aldred, RN, Quality Governance Lead
Signature: Jennifer Aldred
Date: 16/12/2022