

PUTTING PARENTS FIRST: Implementing National Standards for the arrangements and processes associated with post-mortem examination of a baby following a stillbirth

Context and Problem

“Perinatal post mortem rates in the UK are low. This means that many parents are left with unanswered questions about why their baby died, and about what might be done in subsequent pregnancies to avoid further deaths. It also means that there is little information on which to base measures and policies that might reduce the UK’s high perinatal mortality rate” (SANDS)

The National Stillbirth Working Group devised a set of standards that were mandated by Welsh Government and effective from Jan 2016

National Standards

- 1) All parents in Wales suffering the stillbirth or late termination of an infant after 24 weeks gestation must be offered a full post mortem examination (or appropriate limited examination), performed by an appropriately qualified Perinatal Pathologist.
- 2) If full or limited post mortem examination is declined, all parents must be offered expert placental examination by an appropriately qualified Perinatal Pathologist.
- 3) The person obtaining consent for the post mortem must have undergone the all Wales consent for post mortem training and be registered on the National Database held at the paediatric pathology department at University Hospital of Wales (UHW).
- 4) Parents will be given the all Wales information leaflet “Deciding about a post mortem: Information for parents” as a minimum. It is recommended that this should be complemented by the same leaflet produced by SANDS.
- 5) The all Wales consent documentation will be completed to a high standard and copies filed as followed:
 - One copy to the parents
 - One copy filed in the medical notes
 - One copy sent to the pathology department with the baby
- 6) All parents will be given a local contact number for the named person/s responsible for the coordination of the arrangements to transport the baby to UHW.
- 7) All Health Boards will have robust arrangements in place to transport babies to UHW in a timely manner and keep parents informed at all stages of the process.
- 8) Each Health Board should ensure that a designated named person/s is/are in place to monitor the progress of the report and communication with the family.
- 9) The post mortem report will be shared with families at the earliest opportunity within 12 weeks of the post mortem being completed.
- 10) The post mortem report will be discussed and shared with the parents by the Consultant Obstetrician responsible for the woman’s care.
- 11) This should take place in an appropriate environment away from clinical areas.
- 12) A minimum time of one hour should be allocated for this appointment.
- 13) A copy of the post mortem report should be made available to the parents should they wish.
- 14) The parents should be given details of who to contact should they wish to arrange a follow up appointment with the consultant in the event of them having further questions.

Strategy for Change

National Assembly of Wales: Health and Social Care Committee: One day inquiry 2013, Recommendation 8

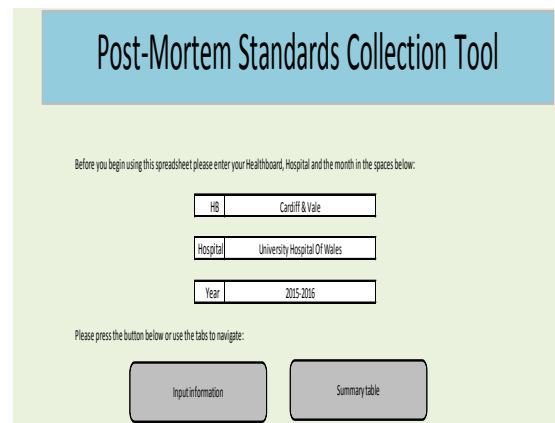
We recommend that the Welsh Government publish a detailed plan of how it proposes to tackle the problem caused by the low rate of post-mortem for stillborn babies

MBRRACE-UK 2015 :Perinatal Confidential Enquiry

All parents of a stillborn baby should be offered a post mortem The placenta should always be submitted for histological examination by a specialist pathologist

Findings can be discussed with parents in an open, honest and constructive way

Measurement for Improvement



Post-Mortem Standards Collection Tool

Before you begin using this spreadsheet please enter your Healthboard, Hospital and the month in the spaces below:

HB	Cardiff & Vale
Hospital	University Hospital Of Wales
Year	2015-2016

Please press the button below or use the tabs to navigate:

Input information	Summary table
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Effects of Changes

The Standards came into effect on the 1st January 2016

The above tool has been developed to assist key people in Health Boards audit the standards

We have started to collect data but it is too early yet to start evaluating the data.

We hope that the existence of Standards will improve the quality of the processes associated with a post mortem and that this will better support parents during their grief and assist them and their care givers in the plan for the next pregnancy.