TRAUMA SERVICE GUIDELINES

Title: **Perinatal Loss Guideline**

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See Also: **Death of a Patient MH Policy**http://ipolicy.mh.org.au/iPolicyV2/ViewPolicyDocument.aspx?policyCode=MH01.04

Adult and Paediatric Cardiopulmonary Resuscitation
http://ipolicy.mh.org.au/iPolicyV2/ViewPolicyDocument.aspx?policyCode=MH02.01.03

Respond Blue and Medical Emergency
http://ipolicy.mh.org.au/iPolicyV2/ViewPolicyDocument.aspx?policyCode=MH02.01.02

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Purpose

As a Major Trauma Service within close proximity of The Royal Woman's Hospital, RMH is designated to care for the pregnant trauma patients. These guidelines have been developed to assist RMH staff in caring for women and their families following the death of their baby.

Definitions [1, 2].

Live Birth:

The birth of an infant who breathes or shows any other signs of life (including heart beat alone) regardless of gestation.

Miscarriage:

The birth of an infant who shows no signs of life after birth, having been born before 20 weeks gestation or - if gestation is not known - weighing less than 400 grams

Still Birth:

The birth of an infant who shows no signs of life after birth, having been born at 20 weeks gestation or more, or - if gestation is not known - weighing more than 400grams

Neonatal Death:

Death within 28 days of birth of a live born infant born at 20 weeks gestation or more, or - if gestation is not known - weighing more than 400grams

Perinatal Death:

A stillbirth or neonatal death.

For the purpose of this guideline any one of the above will be referred to as a perinatal death.

Aim

- To provide dignified, compassionate and supportive care for a deceased baby and his/her family
- To complete all necessary documentation
- Support the nursing and medical staff in their ability to care for the patients, family and their baby
- Support the multidisciplinary team caring for themselves.

Background

It is estimated that 1 in 12 pregnancies will be complicated by trauma. Motor vehicle accidents are the most common cause of blunt trauma in pregnant women. Other causes include falls and assaults. Trauma is the most common cause of non-obstetric fetal and maternal mortality [3]. This rate increases with the gestational age, with just over half of all reported incidences occurring in the third trimester of pregnancy [4]. Perinatal mortality depends on the severity of the trauma and the mechanism of injury [3-16].

In Australia in 2002 the fetal death rate was 6.7 per 1,000 births, neonatal death rate was 3.1 per 1,000 live births and perinatal death rate was 9.8 per 1,000 births [17].

In 2004 Victoria had 63,082 live births and 421 still births, 30% of these were emergency caesarean sections for failure to progress , (32%) malpresentation (12%) and fetal distress (31%)[18] . It can be difficult to determine the effect of trauma on perinatal mortality due to diagnostic and coding interpretation.

Overall perinatal death rates have been stated from 1-34% and risk factors that contribute to fetal loss are maternal death, maternal injury severity and the presence of a abdominal injury and haemorrhagic shock. The most common cause of fetal death being maternal death or placental abruption [13] (note: seat belt injuries are a major precursor to placental abruption and fetal death in utero).

Please see the Pregnancy and Trauma Guidelines for more information.

Guidelines for Caring for a Deceased Baby

Please ensure that you are aware of the families' cultural and religious beliefs before caring for the baby and family as these differences can change the way you attend to their care.

Before delivery

If there is a suspected or known poor prognosis for the neonate Social Work and /or Pastoral Care at The Royal Melbourne Hospital should be offered if time allows and the mother's condition allows for this interaction. This may be very important for parent's wishing to observe particular rituals e.g. baptism. Provide support for the father or other family members should surgical intervention separate them from the mother.

If delivery is imminent a the Neonatal Response Team should be initiated via RWH switchboard Ph: 8345 2222. This will alert RWH's Obstetric, Neonatologist and Anaesthetic registrars who will present to RMH.

After Delivery

If you have time prior to the delivery collect the Perinatal Loss Kit from the OPERATING THEATRE which is kept in Recovery, Level 3 Admissions Bay, outside anaesthetic NUM's office (Recovery/ Anaesthetics phone on #6313 or extension 28621).

Contents on the Perinatal Loss Kit The perinatal loss kit should contain all the items that you will need to care for the baby and mother and complete all the necessary paperwork	
Perinatal Loss Guideline Paperwork Clothes Memory Booklets	Cord Clamps Stamp Booklet +/- Baby Carrier Cot card

Care of the baby

If there have been some active efforts of treatment or resuscitation please leave all tubing and lines in-situ, seal the wounds with gauze and sleek if necessary. Clamp the Intercostal catheters with a cord clamp and cut the excess to a manageable length. If this is very distressing for the family, you can contact the Coroner Court and discuss the issue with them, some of the tubes and lines may be able to be removed, but only once discussed with the Coroner's Court.

Dressing and bathing the baby is not a priority and can be conducted after discussion with the family about their wishes. If the baby is a Coroners case washing should be discussed with the Coroner as this can wash away any forensic pathology. If the baby's death is not going to be investigated by the Coroner and a discussion has taken place with the family, the baby can be washed. In the meantime, wipe the baby with a clean soft wet cloth, wrap her/him in a clean blanket (from the perinatal loss kit), showing the parents you care and respect their child. Dressing and undressing the baby is discouraged (unless requested by the family) especially if he/she is not full term as this can cause deterioration of the baby. If the babies' death is to be investigated by the Coroner's Court do not wash or wipe the baby clean as this could remove important forensic evidence.

Viewing the baby

Every parent should be given an opportunity to decide if they wish to see and hold their baby. Parents/families should be encouraged to hold and touch their baby, never forced and allowed to change their mind if they wish. Private time/ space should be available to enable them to say goodbye.

This is particularity important if the baby died in utero as the ability to see and hold the baby helps establish the reality that their baby is dead. Some parents will respond to encouragement to do so but for others this may feel too traumatic and/or be a culturally unacceptable to do so. Some parents will want to spend extended time with their child and others will not want to see or hold their baby at all.

Be aware that a seriously ill woman who has been denied the opportunity to see and hold her baby, but whose partner or family members have experienced the opportunity may feel that she has been denied and may be resentful towards those family members because they have been the recipients of an opportunity she has missed out on.

If there are fears about the baby's death or the baby appearance, staff can assist by describing gently and honestly how the baby looks. Ensure that someone stays with the family for the first visit.

Involve social work /pastoral care as early as possible, if the family wishes, They will be able to assist both you and the family to deal with this difficult situation.

The mother may also need advice about lactation suppression if applicable and required. If there are no family with the mother, and she is not conscious, the baby can be sent to the mortuary until the family arrive and/or the mother is awake. Place the baby in the baby carrier (from perinatal loss Kit), there is no need to dress or undress baby. Inform the mortuary that you are ready for the baby to be collected. If the baby's death has been reported to the coroner keeping the baby for long periods of time will need to be discussed with the coroner.

The Mortuary

Access

Business Hours: Access to the mortuary during business hours of via security who have a key

Out of Hours: Nursing administration will need to be contacted and have a key for access

Removing a baby from the morgue:

Logging the body: the baby's body should be logged in the mortuary register as usual for an adult. If you remove the body write in the viewing column where the baby has been taken i.e. ICU bed 5, 7SW bed 34

Returning the baby to the morgue

When returning the baby after viewing log the baby back in on a new line as in the first instance.

Ensure that once the family is ready the Coroner's Court or the families chosen Funeral Director is notified to so they can collect the baby.

Creating a Memory Folder [2, 19, 20]

Consent must be obtained from parents before collection or storage of any mementos, including photographs

The memory folder and the items you will require to put it together can be found in the Perinatal Loss Kit.

The Kit contains a memory book, name bracelet, cot card, scissors, cord clamps, stamp pad; clothes (including booties & hat), blanket, measuring tape, medical illustrations request form and paperwork.

If the clothing provided is not correct, more are available in theatre, or you can access some from the birthing suite.

Some parents may want a memory folder and photographs prepared, but do not feel able to take them home immediately. Memory folders can be stored in the envelope provided in the perinatal death kit and then filed in the patient's medical record.

Memory Folder

Consider the following items for the memory folder, depending on what parents want

- Cut 2 locks of the baby's hair
- 2 sets of the baby's hand and footprints
- Name bracelet
- Cot card : complete this card with all the required details including weight & length
- Cord clamp
- Photographs

Photography

The opportunity to take photographs should be offered to every family. Occasionally cultural practices will discourage the taking images of the dead. Please document your discussion and the parent's approval in the medical record.

Photography of the baby is not urgent and more professional photographs will be taken by Medical Illustration. So if time permits waiting a few hours might mean a nicer outcome for the family.

Photos may be taken even if the family do not wish to see the baby. Families may change their minds at a later and for most parents these pictures will be a cherished, permanent and tangible memory of their infant. [20]

To request bereavement photographs, please fill in a Medical Illustration yellow request card (available in the Perinatal Loss Kit) and phone ext 27233. It is preferable to book in an allotted time, please give as much warning as possible. Medical illustrations will not be available after hours or on weekends. If photography cannot wait until business hours then another camera will need to be used.

If the family do not wish to take the photos please store them in the photo folder and file with the medical record.

It is suggested that more than one photo is taken. If taking the photographs yourself, take some with the baby wrapped in a blanket and some with the baby unwrapped and if possible with the family. Be sensitive about lighting and pose the baby in a sensitive and realistic manner (try to think how the baby will look best). [21]. A baby whose skin is in poor condition or is of a poor colour will often look better in black and white photographs.

More information can be found in the bereavement and photography guideline (Trauma Service Website & in Perinatal Loss Kit)

Legal Issues and Documentation

A birth must be registered if:

- Live Birth
- The baby shows signs of life at birth or
- The mother is 20 or more weeks pregnant when baby dies or
- The baby weighs more than 400 grams if dates are unknown
    - This includes still births

A birth cannot be registered if:

- The baby shows no signs of life at birth **and** the mother was less than 20 weeks pregnant when the baby died

or

- The baby weighs less than 400 grams if the dates are not known.

Reporting a Perinatal death to the Coroner

The death of a live born infant must be reported by medical staff to the Coroner under the same circumstances as any other "reportable" death. The Coroner's Court does not investigate stillbirths.

Note: If the child has never been outside a hospital (including ambulance), the death is not "reviewable".

If unsure please contact the Coroner's Court who will assist in this decision making.

Notifying the Coroners Court & Documentation

- Call the Coroners Court of Victoria and report the death (Doctor)

  The Coroners Court of Victoria
  57-83 Kavanagh Street Southbank, 3006.
  Melways Map 2F, square E9
  Call 96844380 or 1300309519 24 hours a day 7 days a week
  Fax 9682 1206

- Complete an electronic medical deposition for all cases reported to the Coroners Court to report the death
  - You will be provided with instructions and a unique reference number to use in this online system
- Complete statement of identification (Family and Doctor)
- Medical Records must be transferred with the deceased to the CoronersCourt

For Cases requiring Post Mortem examination

All cases referred to the Coroners Court will have a preliminary examination completed; this includes an external examination of the deceased, a review of medical records, preliminary toxicology tests, and a review of radiology post mortem (CT scans).

Once the preliminary examination is completed, the Coroner may or may not direct that an autopsy is to be conducted. The Next of Kin can ask the Coroner to reconsider the direction that the autopsy will be performed (external examination instead of full autopsy); however the Coroner has the final say in this.

It is therefore important that this process is discussed with the family so that they have an understanding of what to expect. This should be done by a Trauma Consultant/Registrar or Obstetric Consultant.

Medical Certificate and Baby identification

A Medical Certificate of Cause of Perinatal Death (MCCD Perinatal) and Consultative Council Forms (white page included with MCCD) must be completed for all Registered Births.

If the death is to be investigated by the Coroner this paperwork does not need to be completed.

It is essential that all legal documentation have the exact same name written on them. E.g. Medical Certificate of Cause of Perinatal Death, Registration of Birth, and any other documents.
If there is any discrepancy at all Funeral Directors cannot proceed with burial/cremation and it may mean that families will need to go and re-identify the baby's body [22].

If the baby has not been given a first name – either leave blank or write "baby".

Any alteration to a death certificate must be accompanied by a letter of explanation.

Legally accepted examples include:

Baby Sam Smith (baby of Jan Jones)

Or

Baby of Jan Jones (Name: Sam Smith)

If the placenta or another specimen is to be sent with the body, complete a pathology request and ensure the clinical notes section is complete. This will be sent to the Coroner's Court with the neonate.

Care of the Mother

The covering medical team should liaise with the obstetric team and be guided by them in regard to an ongoing obstetric care.

The mother will need to have a postnatal check each day for the first 3-4 days following a vaginal delivery and 4-5 days following a Caesarean Section to prevent postnatal complications. This needs to be done tactfully and sensitively.

A midwife may need to be sourced from the RWH if more advice required (*See the attached Postnatal Care Plan*).

Women who deliver close to term may need assistance with suppression of lactation.

Ensure that the mother wears a firm fitting bra to support the breasts. Provide simple analgesia as needed for example paracetamol PRN. Assess the breast several times daily for symptoms of mastitis such as redness, lumps, and signs of engorgement or pain.

Breast milk production is a direct feedback mechanism. Therefore, avoid expressing the breast as this will only stimulate further supply (more breast milk being produced). If however, the breast is very uncomfortable and engorged a small amount of gentle expression can provide some relief.

Use of medications to suppress lactation can be discussed with the Obstetric and covering medical team.

See the attached Postnatal Care Plan as a guide. This should also be used to document the postnatal check.

All RMH inpatients should be referred to RMH's pastoral care services whilst an inpatient at RMH.

Perinatal Loss Paperwork

1. Miscarriage
Pre 20 weeks and shows no signs of life

In Victoria, if a baby is delivered before 20 weeks gestation, or if gestation dates are not known and the baby weighs less than 400grams, and has not breathed, the baby is termed a miscarriage. Therefore:

- Registration of birth is not possible; the parents will not receive a birth certificate; thus registration with Births Deaths and Marriages is not possible
- Parents are entitled to take their baby home if they wish
- Parents may choose a formal burial or cremation but this is not compulsory

Cemeteries/crematoria require a letter signed by the attending Medical Practitioner that identifies the name of the baby or the baby's' mother and confirms that the baby is of less than 20 weeks gestation, outlines cause of death and permits cremation or burial.

- If parents would like a funeral they will need to choose or be referred to a Funeral Director.

Paperwork:

- *Medical Certificate for Funeral*

2. Still Born
≥ 20 weeks gestation with no signs of life after birth

Please NOTE: The Coroner's Court does not investigate stillbirths

A baby is referred to as still born if born at 20 weeks or more , or if gestation dates are not known and the baby weighs more than 400 grams, and there are no signs of life after birth.

Requirements:

- Registration of birth is required: birth certificate issued will read "Stillborn"
- Registration of death is not possible

Births, Deaths and Marriages state that if a baby has not breathed outside the womb, then it was never alive; this concept may be difficult for parents to understand.

Paperwork:

- *Doctors Medical Certificate for Funeral*
- *Statement of Identification (available to complete online or photo copy)*
- *Registration of Birth*
- *Perinatal Statistics Form (pink text)*
- Medical Certificate of Cause of Perinatal Death (MCCD Perinatal)
- Consultative council form (white page included with MCCD)

3. Neonatal Death
Infant who shows any signs of life, and who dies within 28 days of birth, [22]

If the baby is 20 weeks gestation or more, and shows any signs of life after birth, for any time period, but dies before he/she is 28 days old then the requirements are:

- Registration of birth is required: birth certificate is issued
- Registration of death is required
- Reporting to the Coroners Court is required

Paperwork :

- *Doctors Medical Certificate for Funeral*
- *Statement of Identification (available to complete online or photo copy)*
- *Registration of Birth*

The following 2 forms are only completed for cases which are not investigated by the Coroner

- *Perinatal Statistics Form (pink text)*
- Consultative council form (white page included with MCCD)

Coroners contact details

The Coroners Court of Victoria
57-83 Kavanagh Street Southbank, 3006.
Melways Map 2F, square E9
Call 96844380 or 1300309519 24 hours a day 7 days a week
Fax 9682 1206

All cases referred to the Coroners Court will have a preliminary examination completed; this includes an external examination of the deceased, a review of medical records, preliminary toxicology tests, and a review of radiology post mortem (CT scans).

For coronial Post Mortems consent is not required; hence the forms below are an expression of the families' wishes; these are available in the resource folder of the perinatal loss kit.

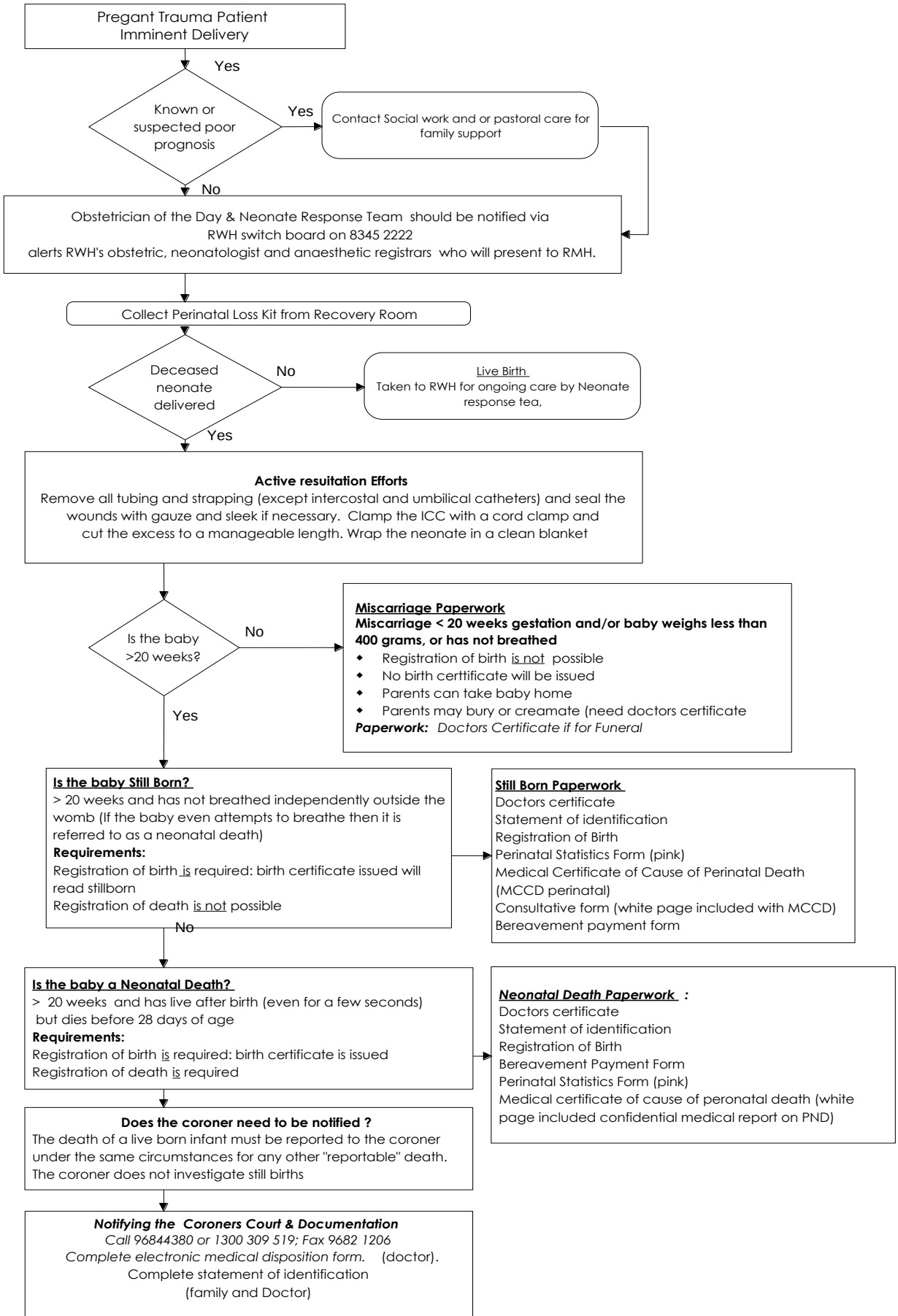
APPENDIX 1: Perinatal Loss to Do's

ISSUES FOR DISCUSSION/TASKS	PREFERENCES, DECISIONS MADE & FOLLOW-UP REQUIRED	SIGNED & DATE
Immediately following birth ☐ Tape cords and lines if resuscitation undertaken ☐ Wipe baby with soft cloth (if not a Coroners case) ☐ Wrap in blanket		
Spending time with the baby after birth ☐ Holding/touching ☐ Bathing/ dressing ☐ Photography		
Photographs ☐ Parents own camera ☐ Hospital Camera (in ND box) ☐ Medical Illustrations (during office hours)		
Memory Booklet (tick if given to parents) ☐ Name Bracelet ☐ Memory booklet ☐ Locks of hair ☐ Cot Card ☐ Foot & hand prints ☐ Hospital clothes & quilt		
Memory Booklet ☐ Taken by parents ☐ Not taken by parents *(only photographs and memory booklet can be kept in medical record)*		
Rituals/ religious faith support ☐ Blessing/naming/baptism ☐ Funeral service		
Funeral Arrangements *(usually discussed with pastoral care social worker)* ☐Taking baby home ☐Hospital arranged cremation burial ☐Private burial/cremation ☐ Hospital Service		
Bereavement package ☐ Death Certificate (to go with baby) ☐ Memory Booklet ☐ Birth registration		
Other:		

APPENDIX 2 : Post Natal Care Guideline

<table>
<tr><td colspan="4">BIRTH DETAILS</td></tr>
<tr><td colspan="4">MOTHERS NAME:</td></tr>
<tr><td colspan="2">PARTNERS NAME:</td><td colspan="2">BABIES NAME:</td></tr>
<tr><td colspan="2" rowspan="2">DATE AND TIME OF BIRTH:
DATE: TIME:</td><td colspan="2">GESTATION IN WEEKS:</td></tr>
<tr><td colspan="2">MALE /FEMALE (CIRCLE)</td></tr>
<tr><td colspan="2">BIRTH WEIGHT:</td><td colspan="2">APGAR SCORES @</td></tr>
<tr><td colspan="2">HEAD CIRCUMFERENCE</td><td colspan="2">1 MINUTE:</td></tr>
<tr><td colspan="2">LENGTH:</td><td colspan="2">5 MINUTES:</td></tr>
<tr><td colspan="2">RHD STATUS</td><td colspan="2">RHD IMMUNISATIONS:
DATE: TIME:</td></tr>
<tr><td colspan="2">NORMAL VAGINAL BIRTH SUMMARY
Please complete for all vaginal deliveries</td><td colspan="2">CAESAREAN SECTION BIRTH SUMMARY
Please complete for all Caesarean Section</td></tr>
<tr><td>PLACENTA:</td><td>☐ COMPLETE
☐ INCOMPLETE</td><td colspan="2" rowspan="2"></td></tr>
<tr><td>MEMBRANES</td><td>☐ COMPLETE
☐ INCOMPLETE</td></tr>
<tr><td rowspan="2">INSTRUMENTAL DELIVERY:</td><td>☐ FORCEPS</td><td colspan="2" rowspan="2">Do not palpate the fundus following a C/Section</td></tr>
<tr><td>☐ VENTOUSE/SUCTION</td></tr>
<tr><td colspan="2">FUNDAL HEIGHT: (Tick Appropriate Box)</td><td colspan="2">WOUND: (Tick Appropriate Box)</td></tr>
<tr><td colspan="2">☐ AT UMBILICUS</td><td colspan="2">CLEAN, DRY AND INTACT YES ☐ NO☐</td></tr>
<tr><td colspan="2">☐ 1 CM BELOW</td><td colspan="2">BRUISING/SWELLING YES ☐ NO☐</td></tr>
<tr><td colspan="2">☐ 2 CM BELOW</td><td colspan="2">SUTURES YES ☐ NO☐</td></tr>
<tr><td colspan="2"></td><td colspan="2">OTHER YES ☐ NO☐ SPECIFY:</td></tr>
<tr><td colspan="2">PV LOSS: (tick appropriate box)</td><td colspan="2">PV LOSS: (tick appropriate box)</td></tr>
<tr><td colspan="2">AMOUNT: SMALL ☐ MEDIUM ☐ LARGE☐</td><td colspan="2">AMOUNT: SMALL ☐ MEDIUM ☐ LARGE☐</td></tr>
<tr><td colspan="2">CLOTS PRESENT: YES ☐ NO☐</td><td colspan="2">CLOTS PRESENT: YES ☐ NO☐</td></tr>
<tr><td rowspan="3">LOCHIA</td><td>RUBRA (BRIGHT RED): YES ☐ NO☐</td><td rowspan="3">LOCHIA</td><td>RUBRA (BRIGHT RED YES ☐ NO☐</td></tr>
<tr><td>SEROSA (PINKISH) YES ☐ NO☐</td><td>SEROSA (PINKISH YES ☐ NO☐</td></tr>
<tr><td>ALBA (WHITE) YES ☐ NO☐</td><td>ALBA (WHITE) YES ☐ NO☐</td></tr>
<tr><td colspan="2">PERINEUM (tick appropriate box)</td><td colspan="2" rowspan="6"></td></tr>
<tr><td colspan="2">INTACT ☐ SWOLLEN ☐ BRUISED ☐</td></tr>
<tr><td colspan="2">HAEMATOMAS EVIDENT:YES ☐ NO ☐</td></tr>
<tr><td rowspan="3">TEARS:</td><td>1ST DEGRE:YES ☐ NO ☐</td></tr>
<tr><td>2ND DEGREE:YES ☐ NO ☐</td></tr>
<tr><td>3RD DEGREE: YES ☐ NO ☐</td></tr>
<tr><td colspan="2">EPISIOTOMY: HEALING ☐ GAPPING ☐ NA ☐</td></tr>
<tr><td colspan="2">LABIAL TEARS: YES ☐ NO ☐</td></tr>
<tr><td colspan="2">ANALGESIA AS ORDERED</td><td colspan="2">ANALGESIA AS ORDERED</td></tr>
<tr><td colspan="2">BOWEL CARE: DAILY BA ☐ APERIENTS ☐</td><td colspan="2">BOWEL CARE: DAILY BA ☐ APERIENTS ☐</td></tr>
<tr><td colspan="4">BREAST CARE:</td></tr>
<tr><td colspan="2">☐ FIRM FITTING BRA
☐ MONITOR FOR SIGNS OF INFECTION/ENGORGEMENT
☐ MEDICATIONS AS ORDERED TO REDUCE SUPPLY (DOSTINEX)</td><td colspan="2">☐ GENTLE EXPRESSION IF UNCOMFORTABLE.
☐SIMPLE ANALGESIA FOR COMFORT</td></tr>
<tr><td colspan="2">☐ DVT PROPHYLAXIS AS ORDERED
☐ TEDS</td><td colspan="2">☐SOOB & AMBULATE EARLY IF ABLE</td></tr>
</table>

APPENDIX 3: Perinatal Loss Guideline



APPENDIX 4 : Bereavement Care

Support for family

The death of a neonate is one of the most tragic events that a family can experience. It is usually unexpected thus parents are unprepared. This experience is multiplied when the health of the mother is also at risk which may be the case for the pregnant trauma patients who are cared for at RMH [19, 20].

It is important when caring for a family who has suffered a neonatal loss to recognize and acknowledge that their baby is unique and irreplaceable. Parental bonding with a baby may begin as early as conception and for some women during the anticipation of conception and pregnancy. As caregivers Nurses, Pastoral Carers and Social Workers are in a unique position to provide a level of care and sensitivity that can greatly assist families in their grieving process [20].

While the family will need to make a number of decisions, care needs to be taken that these are not rushed. Supportive care from Nursing Staff, assisted by Pastoral Care, Social Work and The Women's can enable a calming of the panicked and/or immobilised family resulting from the shock and grief. Facilitation of decision making that is meaningful and supportive is essential for their on-going grief journey.

Common Grief and Loss Reactions

Importance of Culture

Culture and tradition play a large role in the grieving process. Culture frequently impacts on an individual's or a family's response to loss. By approaching family members with a supportive non judgemental attitude, staff will be able ascertain if certain practices are significant for the family.

The culture, belief system and tradition may affect the amount of time parents want to touch and/or hold their baby and also how much they want the staff to handle their child. [23].

Pastoral Care and Social Work team members have access to reference materials highlighting particular faith and cultural group responses and needs. However each person gives expression to their grief based on their individual personality and experience. It is vital to acknowledge the uniqueness of each situation.

It can be particularly important to observe gender roles adopted by the family members present and work within these frameworks, remaining sensitive to the needs of **each** person involved. For most people the experience of a neonatal death is new and unknown. Families and couples often benefit from reassurance that their reactions are normal given the emotional and physical trauma they are experiencing. These emotions may feel strange and confusing to them. Gentle suggestions as to what may be helpful can guide them towards actions that make their bereavement more meaningful.

Family's grief reactions can include:

Disbelief: Parents and families will almost always experience an initial period of disbelief and shock at the death of their baby and the loss of joyous expectancy associated with the pregnancy.

Numbness: Is often associated with disbelief and can be present for either parent. Numbness is an internal retreat to a safe place behind the pain until sufficient time has passed to enable the intensity of feelings to be felt and expressed. Decision making, remembering details and communicating effectively, can be difficult in this phase.

Separateness: Some couples experience a distressing sense of emotional and physical separation at the death of a neonate. Fathers may feel unable to share the depth of the mother's experience and can feel undeserving of care for themselves, focusing on their partners. Sometimes a mother's grief also prevents her from acknowledging and responding to the loss felt by her partner. The loss of a neonate often places a relationship under severe stress. Staff need to be attentive to differing levels of grief expressed by each partner. Family members may also experience being unable to "reach out" to each other emotionally and experience distress at this loss of mutuality and support.

Reasoning Why: Questions as to what happened and what steps were taken to save the neonate and/or mother are a response to the sudden loss of all control and feelings of helplessness. Questions need to be answered and re-answered with gentleness, simplicity and honesty to assist this process.

Anger: Some parents will express deep anger over the death of their baby. Anger may be directed at God, Doctors, Nursing staff, the other partner and the other people or person involved in the accident. Should the anger be distressing for others involved, the support of Pastoral Care or Social Work can be

helpful in providing a safe place for this to occur. Anger is a normal grief reaction and may emerge immediately or remain unacknowledged and unexpressed for a longer period of time. Sensitive listening and attention to body language can assist in the naming of these feelings. It is vital that a person be able to express theses feelings safely.

Disappointment and Fear: Because of the joyous expectation for the forthcoming baby, the death of a neonate can be such that the disappointment is almost unbearable. Parents are vulnerable to the fear of disappointing and letting down the other partner when a neonatal death occurs. If the death has been complicated by injuries or illness, a fear of being unable to conceive and carry another pregnancy to full term is also common.

Self blame and Guilt: Parents can express a sense of responsibility over the death of their baby. Feelings of guilt may appear rational or irrational. These behaviours could be the only way the parent can express their helplessness. They may follow or merge with numbness, anger and fear. Acknowledging the intensity of this helplessness as their present experience is a first step toward enabling parents to regain a healthy perspective and begin the grieving process.

What can we do or say to help

It is important to remember that grief is not proportional to the size of the person who has died. That the loss of a baby is not substituted by the birth of another [19]. Therefore be careful not to rationalise the loss with comments such as "you can have other babies"; or "you have more children at home"

Questions that may help to reassure and open communication line with the grieving parents are:

- Reassurance that their grief and expression of feelings are normal
- Say I am sorry; this must be so hard; how can I help?
- What are their traditions when a baby dies?
- Is there someone I can call?

Using gentle prompts if necessary, allow parents space and time to speak of their feelings and what is important for them.

Other suggestions

- Try to be your yourself
- Don't try to ask questions about things you don't understand
- Be sympathetic
- Allow the parents and their families time to grieve

Staff Support

Fortunately most RMH staff will only have to deal with this situation on rare occasions. Many will find the event very stressful and sometime significantly distressing. This can apply equally to both new and experienced staff. Don't see it as a personal failing, but rather as a marker of your compassion for what the family is experiencing.

It is normal to experience grief at the death of a patient who has been in your care, many of you peers and those around you who have been involved in the care of the patients will be experiencing similar feelings.

It is not the norm to discuss our own feelings in death, but this can be a helpful process for dealing with our grief. The RMH's Peer Support (Pager 123) is available for 'one on one sessions' or a group debrief can be organised.

More suggestions include:

- Have some time alone, it is ok to cry
- Sit, debrief and have coffee with others who have been involved with this patient
- Seek help if you have reoccurring thought and dreams
- Counselling

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