



Royal College
of Nursing

Sensitive disposal of all fetal remains

Guidance for nurses and midwives



Royal College
of Nursing

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Introduction

The aim of this document is to provide guidance to nurses and midwives on how to ensure that arrangements are in place to provide sensitive disposal of all fetal remains, whether in a NHS trust hospital, private clinic or in a primary care setting.

Fetal remains in the context of this document refers to all fetal tissue obtained following surgical procedures for miscarriage and termination, natural miscarriage, medical treatment of miscarriage or termination, and any fetus born dead before 24 weeks gestation.

The guidance should be used in conjunction with Stillbirth and Neonatal Death Society (SANDS) (1995) *Pregnancy loss and the death of a baby – guidelines for professionals* and the Institute of Cemetery and Crematorium Management (ICCM) (2004) *Policy document for the disposal of fetal remains*.

The SANDS guidelines are essential reading for anyone working in this area. They give excellent information and guidance to staff on the practical support that couples need when faced with pregnancy loss.

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Background

Discussion about sensitive disposal of fetal material began with the Polkinghorne report (1989) which acknowledged the special status of the fetus:

“On the basis of its potential to develop into a human being, a fetus is entitled to respect, according it a status broadly comparable to that of a living person. Thus, the relevant categories of ethical significance are ‘alive’ and ‘dead’, and the category of ‘pre-viable’, used in the Peel Report, is not of ethical significance.”

Polkinghorne (1989) page 20

Although the main aim of the Polkinghorne report was to provide guidance on the use of fetal material in research, it sparked many debates. The NHS Management Executive responded with guidelines on the disposal of all fetuses and fetal material (1991a, 1991b). These guidelines said that disposal should be sensitive and respectful, irrespective of how the pregnancy was lost. The minimum requirement was that all fetuses and fetal material should be stored separately in secure containers, and transported and loaded separately for incineration – an impossible procedure with modern incinerators.

The guidance is clear that staff should consider any personal wishes expressed by the parents. It suggests one way of identifying whether practices are suitable is if staff feel able to answer parents’ questions on the method of disposal without causing distress.

The SANDS (1995) guidelines for professionals also argue the need for sensitive disposal. They emphasise the importance of information for parents – about the choices they can make and about arrangements that will be made if they choose not to be involved.

There is wide variation across the UK on how early fetal remains from miscarriage and termination are disposed of. A survey of trusts and clinics around the UK by the Working Group (RCN Gynaecological Nursing Forum, 1999) found that in the year 2000, most fetal tissue from early losses were incinerated either on or off the hospital site along with clinical waste material. This practice is

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Options available

felt to be completely unacceptable by health professionals working within this area.

Parents should be given the same choice on the disposal of fetal remains as for a stillborn child. They should be clearly and sensitively informed of the options available to them, both verbally and in writing, by trained health professionals.

It is acknowledged that sometimes parents don't recognise their loss at the time, but may return months or even years later to enquire about the disposal arrangements. Therefore, it is important to respect the wishes of parents who may not want to be involved, but to ensure also that sensitive and dignified disposal is carried out.

The following options should be available for disposing fetal remains.

Hospital burial or cremation

- ◆ When the family choose not to be involved – there would normally be a communal cremation/burial. The hospital would usually be responsible for the funding and the arrangements.
- ◆ When the family choose to attend – this would normally be an individual cremation/burial. The hospital would usually be responsible for the funding and the arrangements, informing and involving the parents as appropriate.

Private burial or cremation

The parents should be aware that they can make suitable arrangements themselves, but they may have to incur some or all of the costs. The hospital should be able to offer the necessary information and documentation.

Burial outside a cemetery

SANDS guidelines say there is no legal prohibition to parents taking fetal remains home to bury themselves, provided certain requirements are met. These are:

- ◆ it must not cause any 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 onto adjoining land
- ◆ the fetal tissue must be buried at a depth of at least 18 inches (45cm)

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Suggestions to improve practice

- ◆ 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 is used for new purposes in the future.

Health professionals may wish to offer additional support to parents who choose this option. If parents have any queries, it may be helpful for a health professional to follow these up on their behalf.

Additional information on alternative forms of disposal can be obtained from the ICCM.

Please note that in Scotland there is an issue of whether multiple cremation/burial is allowed. A negative response to such a request may be due to local policies and we recommend that you make contact with the Institute of Cemetery and Crematorium Management (ICCM) for help regarding any problems encountered (see Appendix B).

This section is intended as a guide for nurses and midwives working within the area of pregnancy loss or termination, and offers practical advice, ideas and solutions on sensitive disposal. The questions and answers are based on experiences of others from around the UK.

This document refers to both cremation and burial. Local policies on the main method of disposal should be developed according to local needs, religions, cultures and available services. It is vital that both options are open to parents to give them choice. If communal burial is offered, it must be noted that there could be potential problems, for example, it would not be possible for a family to have an exhumation at a later date and the memorial on the grave will not record individual names.

We refer to the “woman” but realise in many cases that this may be interpreted as parents or couple.

Q1: Local crematoria/burial grounds state that all fetal remains, regardless of gestation, need to be cremated or buried in separate caskets to comply with their code of practice. This leads to major cost and organisational difficulties. Is there any way around this?

A: Until recently, communal cremation/burial was at the discretion of local crematoria. However, the ICCM has now agreed to the communal cremation/burial of fetal remains provided that documentation is complete and accompanies the remains. This would need to be negotiated at local level and a hospital contract organised (see appendix A).

Q2: What paperwork is required following pregnancy loss before 24 weeks?

A: Legally these pregnancies are termed pre-viable and therefore do not need to be registered or certified.

Crematoria/burial grounds have a legal obligation to ensure that the pregnancy ended “naturally” or “legally”. For this reason most trusts complete pre-viability forms for losses where a tiny fetus has been delivered, often after 12 weeks gestation (although this age varies throughout the UK).

The problem occurs when considering cremation/burial of pregnancy losses after surgical intervention, medical termination or spontaneous early miscarriage. Many areas are faced with a large volume of fetal remains, and it would be impractical to have a separate pre-viability form for each.

The ICCM has agreed that crematoria/burial grounds can accept one form carrying information of several pregnancy losses, signed by the medical practitioner, midwife or nurse (as appropriate). Confidentiality is important and it has been agreed to accept lists as above, which require only a hospital number as identification. However, it is important to keep accurate records to allow traceability of fetal remains should parents request information in the future.

- Q3: How can we ensure that women are aware of the options available for disposal? It is not always appropriate to discuss the issue at the time of miscarriage or termination.
- A: Nurses and midwives will often be the first point of contact and they must provide up to date written information at the time of miscarriage or termination. This information should outline the options available and the time limits for making a decision. The written format must be clear about who to contact in case parents wish to discuss anything with staff. Nurses and midwives are accountable for their own practice and, therefore, must ensure they keep appropriate records (NMC, 2004).

Some units have developed a checklist to ensure that all necessary information has been discussed. Timing is crucially important in discussing issues about disposal with parents. Guidance should be taken from experienced staff as to the most appropriate time.

- Q4: What are the issues in relation to consent?
- A: The ICCM policy document states that the hospital should obtain consent from the parent(s), preferably in writing, authorising the means of disposal. Many units are looking at the issue of consent for disposal, some are including it on the consent form for the procedure whilst others are looking at including it on a consent form for histological examination. Consent is an important issue and should be seriously considered at an early stage in developing a policy for sensitive disposal.

Q5: What happens if the woman does not wish to be involved?

A: Written information must be given to the woman explaining what is available and what arrangements will be made if she chooses not to take part. If the woman expresses no special wishes or any desire to be involved with the final arrangements, this is perfectly acceptable and should be respected.

The hospital or clinic should then follow the procedure for communal cremation/burial.

Some units have suggested adding a section about sensitive disposal to existing consent forms.

Q6: What should be offered to parents who experience the death of one or more babies from a multiple pregnancy before 24 weeks gestation, with at least one baby surviving?

A: A suitably trained professional should discuss the available options with the parents before delivery of the surviving baby. These would include an individual hospital burial/cremation or inclusion in a communal service. The documentation must be completed in the same way as following a miscarriage/termination. Further information on this issue can be obtained from the Multiple Births Foundation (MBF) (1997) guidelines.

Q7: How can we ensure that people from all cultures and religions are cared for appropriately?

A: Both burial and cremation should be available to parents to allow for cultural and religious differences. It is sometimes helpful for parents, whether they have religious beliefs or not, to have the chance to meet with a hospital chaplain to discuss their options and wishes. Where parents are involved in a religious community, they may wish their own religious leaders to help with or make the arrangements.

At a communal burial/cremation the hospital chaplaincy need to show an awareness of the differing spiritual and cultural needs of parents and provide a service that is acceptable to all faith communities, irrespective of whether they attend the service or not.

Q8: How can we offer some form of memorial for the parents?

A: Many units provide a book of remembrance that is kept in a significant place, usually the hospital chapel. Parents should be informed of this, and be aware that they can return at any time to arrange

for an entry to be placed in the book. It is becoming common to offer a monthly or annual service of remembrance which parents are invited to attend. The format of this service would need to reflect the cultural, spiritual and diverse needs of the community that the hospital or clinic serves.

- Q9: At our hospital theatre they use a closed suction system, a sample of fetal tissue goes to histology. What do we do with the rest?
- A: Careful negotiation between nursing, medical and theatre staff can ensure a system that allows for all fetal remains to be collected. Many companies now provide individual tissue traps that can be removed and identified with the woman's hospital number, before being stored in a designated secure place and then taken to the crematorium/cemetery.
- Q10: Plastic tissue collection traps are used in theatre for suction termination of pregnancies and some evacuations of retained products of conception. Can these be cremated?
- A: It is prohibited to use products containing any chloride or fluorides – for example polyvinyl chloride (PVC) or melamine – for cremation purposes. Individual trusts and clinics should check with the manufacturers of their tissue traps to assess if they are acceptable for cremation. The Federation of British Cremation Authorities issues regulations on materials that can be safely cremated (See Appendix B for contact details).
- Q11: What should be included in sensitive disposal, all products of conception or only identifiable fetal tissue?
- A: Whatever is agreed within the Trust/Unit should be clearly explained to the woman both verbally and in writing. The two options would be:
- to include all tissue obtained from termination, miscarriage or ectopic pregnancy, assuming that fetal remains will be within the tissue obtained, or that the tissue represents a pregnancy
 - if histological examination shows that the tissue does not contain any fetal remains then it may not be included in sensitive disposal. If this is the case then there should be a clear process in place to inform the woman that the tissue obtained will not go forward for sensitive disposal, this should include a timescale and a designated person to inform the woman.
- Q12: How can the hospital be sure that all fetal remains are sent for sensitive disposal?

A: Communicate with staff involved so that procedures are put in place to ensure all tissue is returned to a central place before cremation (for example after histology or cytogenetic investigations). Clear and accurate documentation is essential for an audit trail to be followed. All staff should have access to written policies and procedures to ensure that they are aware of their role in the process of sensitive disposal.

Q13: Who should organise/co-ordinate the sensitive disposal service?

A: Who organises the service will vary, but it is important that all staff know who is responsible. In hospital settings it is often co-ordinated by hospital chaplains in conjunction with mortuary staff and sometimes a local funeral director.

Where there is a local maternity department, it would be appropriate to link in with the existing arrangements for organising funerals.

In private clinics this would be arranged directly with local crematoria.

Primary care settings should link in with their local trust.

Many areas have found that forming a multi-disciplinary pregnancy loss group can help in setting up or improving existing sensitive disposal as well as other services related to pregnancy loss.

Q14: What about women who miscarry at home?

A: Many women miscarry at home without realising what has happened. If fetal tissue is obtained, then it is important that primary care staff are aware of local policies and can link in with communal disposal at their local trust.

Q15: How can the potential increase in volume of fetal remains be stored?

A: Some possible solutions include negotiating a specially designated area within the existing mortuary, or providing a safe area in theatres or wards. Staff in these areas must be involved with this decision and be fully aware of the possible need for storage areas and the documentation required.

Most histopathology laboratories will already have storage areas, but would need to link in with local sensitive disposal arrangements for fetal remains after miscarriage, ectopic pregnancy and termination of pregnancy.

Q16: Who bears the costs – parents or the trust/clinic?

A: If the parents have opted to arrange a private burial/cremation they can approach a funeral

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director personally and will incur all costs, although many funeral directors make nominal charges. If the arrangements are left to the hospital or clinic, then they meet all the costs.

Parents can approach the ICCM for advice on all methods of disposal if they wish.

Q17: During recent years advances in fertility treatments have resulted in storage of frozen embryos that are no longer required by the parents. How can we ensure sensitive disposal of unused embryos?

A: The special status of the embryo is fundamental to the Human Fertilisation and Embryology Act (1990) which requires that the creation of human embryos outside the body, whether for treatment or research, can only be carried out in centres licensed by the Human Fertilisation and Embryology Authority (HFEA).

All centres must comply with the HFEA Code of Practice and they are all inspected annually to assess and ensure compliance. The Code of Practice gives guidance about consent, which must by law be given by the providers of gametes from which embryos are to be created. It also has a section on the termination and disposal of embryos. In the future it may be appropriate for fertility units to link in with arrangements of their local trust to ensure sensitive disposal of any unused frozen embryos.

Q18: Can fetal tissue be used for research purposes?

A: Fetal tissue may be required for research. Such research requires application to, and the approval of, the Department of Health. The Research and Ethics Committee in the trust or organisation needs to agree and set out clear guidelines for the project.

If the woman has not expressed any particular wishes about the fetus, she may agree to specific research being carried out. She would be required to sign a consent form to authorise this and to confirm that she fully understands the planned outcome. Following the Bristol and Alder Hey enquiries, the Chief Medical Officer's Report (DoH, 2001) highlighted the importance of obtaining informed consent, and providing clear information and careful documentation.

Q19: How can staff be supported through these changes?

A: This is a sensitive area, and the staff involved need support and education. This applies to the wider

multi-disciplinary team as well as to gynaecology nurses, midwives and theatre staff.

Some areas have found support groups for staff, including chaplains and/or hospital counsellors, to be invaluable in providing a forum where staff can voice experiences or concerns. This can be linked in with teaching on related issues.

Other areas have sessions on pregnancy loss and sensitive disposal as part of staff induction to the gynaecology unit. This is useful if given by an experienced nurse, midwife or chaplain, who can give practical examples and answer questions honestly.

Conclusion

The issues covered in this guidance are by their nature sensitive. This may explain partly why it has taken so long for the issues to be fully addressed. Some of the guidance will need to be taken up and discussed at a local level to enable individual trusts to work towards sensitive disposal of all fetal remains.

Public awareness of sensitive disposal is increasing. This has led to more women wishing to know more about or feel more involved in what happens to the remains of their pregnancy.

Women who do not wish to engage in these issues at the time of their pregnancy loss are equally entitled to sensitive disposal of their fetal remains. Health care professionals are ideally placed to take this work forward to ensure that patients receive the best possible quality of care.



Appendices

Appendix A: Example contract for the disposal of fetal remains

It is hereby agreed thisday of
 20....., that (Burial/cremation
 authority) Borough Council shall dispose of any fetal remains provided by
Hospital for a period of
 twelve months. This agreement shall be subject to the charges detailed below and the conditions contained overleaf.

The charges for the disposal of fetal remains shall be as follows:

- a) Individual Burial £.....
- b) Individual Cremation £.....
- c) Bulk Communal Burial (per bulk interment*) £.....
- d) Bulk Communal Cremation (per bulk cremation*) £.....

I hereby agree to the charges and conditions detailed within this contract.

Signed for and on behalf of
 Council

Address

Witnessed

Address

Signed for and on behalf of
 Hospital

Address

Witnessed

Address

* To be negotiated to meet local needs - no maximum recommended.

Appendix B: Useful contacts

Antenatal Results and Choices (ARC)

73 Charlotte Street
London W1T 4PN

Tel: 020 7631 0280
Email: info@arc-uk.org

British Pregnancy Advisory Service (BPAS)

Amec House
Timothy's Bridge Road
Stratford-upon-Avon CV37 9BF

Tel: 0870 365 5050
Email: comm@bpas.org
Web site: www.bpas.org

Federation of British Cremation Authorities (FBCA)

41 Salisbury Road
Carshalton
Surrey SM5 3HA

Tel: 020 8669 4521

Human Fertilisation and Embryology Authority (HFEA)

21 Bloomsbury Street
London WC1B 3HF

Tel: 020 7291 8200
Email: admin@hfea.gov.uk
Web site: www.hfea.gov.uk

Human Tissue Authority (HTA)

Finlaison House
15-17 Furnival Street
London EC4A 1AB

Tel: 020 7211 3400
Email: enquiries@hta.gov.uk
Web site: www.hta.gov.uk

Institute of Cemetery and Crematorium Management (ICCM)

ICCM National Office
City of London Cemetery
Aldersbrook Road
Manor Park
London E12 5DQ

Tel: 020 8989 4661
Fax: 020 8989 6112
Web site: www.iccm-uk.com

For specific enquiries contact ICCM via:

Chief Executive
107 Parlaund Road
Langley
Slough SL3 8BE

Tel: 01753 771518

Miscarriage Association

C/o Clayton Hospital
Northgate
Wakefield WF1 3JS

Tel: 01924 200795 (admin) 01924 200 799 (helpline)
0131 334 8883 (Scottish helpline)
Web site: www.miscarriageassociation.org.uk

Stillbirth and Neonatal Death Society (SANDS)

28 Portland Place
London W1B 1LY

Tel: 020 7436 7940 (for details of SANDS local groups)
020 7436 5881 (helpline)
0131 6226263 (Edinburgh SANDS)
Fax: 020 7436 3715
Email: support@uk-sands.org
Web site: www.uk-sands.org

The Child Bereavement Trust (CBT)

Aston House
High Street
West Wycombe
High Wycombe
Buckinghamshire HP14 3AG

Tel: 01494 446648
Fax: 01494 440057
Web site: www.childbereavement.org.uk

The Ectopic Pregnancy Trust

C/o Hillingdon Hospital Maternity Unit
Pield Heath Road
Uxbridge
Middlesex UB8 3NN

Tel: 01895 238025
Email: ept@ectopic.org

The Multiple Births Foundation (MBF)

Hammersmith House, Level 4
Queen Charlottes and Chelsea Hospital
Du Cane Road
London W12 0HS

Tel: 020 8383 3519
Email: info@multiplebirths.org.uk
Web site: www.multiplebirths.org.uk

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Further reading



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