

Termination of Pregnancy (TOP) Guideline and Pathway

Purpose of Guideline:

To provide guidance to medical, midwifery and healthcare staff on safe provision of abortion care including

- Safe use of Mifepristone and Misoprostol as per gestational age (*this guideline does not discuss surgical TOP in NI*)
- Accurate completion of relevant documentation
- Bereavement support
- Conscientious Objection

Regulations for Abortion Provision in Northern Ireland

The UK parliament passed the Northern Ireland (Executive Formation etc) Act on 22 October 2019 with immediate changes to the law on access to abortion services. This legal change was supported publicly by the Royal College of Obstetricians and Gynaecologists. Prior to this legislation, abortion in NI was provided for in very few circumstances. Regulations have been introduced, however services have yet to be commissioned.

Abortion may be provided:

- <12 weeks gestational age on a woman's request and with the certification of a healthcare professional
- >12 weeks where
 - continuing the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman, greater than the risk of terminating the pregnancy up to 24 weeks gestation
 - there is a severe fetal impairment and/or fatal fetal abnormalities (no gestational time limit)
 - there is a risk to the life of the woman or girl, greater than if the pregnancy were terminated, or where necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman or girl, including in cases of immediate necessity without any gestational time limit.

Certification is required by one healthcare professional prior to 12 weeks gestation, and by two registered medical professionals >12 weeks gestation. The woman will have been counselled regarding the proposed method of TOP prior to admission to labour ward (usually 36-48 hours following Mifepristone administration) and this certificate will have been completed prospectively.

Notification of the TOP must be made to the Chief Medical Officer (CMO) within 14 days.

Mifepristone/Mifepristone Use in Abortion

Misoprostol is a prostaglandin analogue, commonly used in medical management of miscarriage and TOP to induce myometrial contractions to aid expulsion of pregnancy tissue. To augment the effect of Misoprostol, a steroidal anti-progesterone called Mifepristone can be used to prime the myometrium before prostaglandin exposure.

- Be aware that the uterus is more sensitive to Misoprostol as pregnancy advances
- Be aware of risk factors for uterine rupture including a pre-existing uterine scar, increased gestational age and multiparity.
- Mifepristone is contraindicated in uncontrolled asthma, chronic adrenal failure, severe liver or kidney disease and porphyria

Medical Abortion between 10+1 and 23+6 weeks

- Offer 200mg Mifepristone
- 36-48 hours following Mifepristone, offer an initial dose of Misoprostol 800mcg PV or 600mcg SL
- Follow this initial dose with 400mcg Misoprostol (PV/SL/Buccal) every 3 hours until delivery of the fetus.

Medical Abortion between 24-25 weeks

- Offer 200mg Mifepristone
- 36-48 hours following Mifepristone, offer 400mcg Misoprostol 400mcg (PV/SL/Buccal) every 3 hours until delivery

Medical Abortion between 25+1-28 weeks

- Offer 200mg Mifepristone
- 36-48 hours following Mifepristone, offer 200mcg Misoprostol (PV, SL, Buccal) every 4 hours until delivery .

Medical Abortion >28/40

- Offer 200mg Mifepristone
- 36-48 hours following Mifepristone, offer 100mcg Misoprostol (PV, SL, Buccal) every 6 hours until delivery.

Previous C-Section – *The risk of uterine rupture should be discussed with the patient (evidence defining risk is limited) – consider treatment with Mifepristone, omit loading dose where applicable and half dose of misoprostol.*

Commence on Admission

Before Delivery

Care and Support on Admission →

1. A suitable side ward should be made available for the woman and her partner
2. The woman should be supported by a midwife who holds no conscientious objection to termination of pregnancy
3. Where possible, and if they wish to do so, the parents should be given the opportunity to discuss the plan of care with the senior Obstetrician on duty
4. Commence partogram when in labour

Discussion and information on the care choices available →

1. The frequency and route of Misoprostol administration.
2. Analgesia options should be discussed and should not be restricted due to event of TOP
3. Discuss any special or cultural requests including wishes on who will be present at delivery and whether they wish to see or hold the baby.
4. Palliative care should be commenced if the fetus is born alive (see Appendix 1) .
5. Post-Mortem information leaflet should be provided. Where a baby is born with signs of life or stillborn after 24 weeks the coroner should be informed.
6. Management of lactation should be discussed including
 - a. suppression of lactation with 1mg of Cabergoline should be discussed and offered
 - b. option of milk donation if wishes
7. Referral to the bereavement midwifery team should be offered (see page 7)

After Delivery→

1. Record OEWS score and escalate to senior midwifery staff or medical staff if required
2. Provide postnatal care as per the vaginal delivery pathway in the regional maternity notes
3. If baby is born with signs of life, an Obstetric doctor should attend to perform an examination and then to confirm life extinct and provide a death certificate (see appendix 2)
4. The baby should be weighed and a description of any abnormal features should be recorded in these notes (see page 9). Medical photography photographs may be requested for filing in the notes if written consent is obtained as per local policy.
5. Support the woman and her wishes regarding seeing and touching the baby. If desired a moses basket should be made available beside the woman's bed with the use of a cooling blanket to preserve the body.
6. The woman should be offered a 'memory pack', photographs and hand and foot prints if she wishes
7. Obstetric Registrar or Consultant should discuss post-mortem options and a PM form should be completed even if the woman does not wish a post-mortem to be performed. If PM is declined placental investigations to include histopathology +/- genetic investigation should be discussed.
8. Parents should be offered family directed burial/cremation or hospital cremation and choice should be documented on PM form (parents who choose post-mortem and wish to be contacted by Alderhey bereavement team should have this noted on the special requests section of the PM form)
9. The placenta should be checked for completeness, weighed and findings documented as per usual care.
10. If post mortem is to be completed, the placenta should be placed in a dry, white labelled container and kept in the body fridge until transfer to the mortuary with the baby.
11. If there is no post mortem to be completed, discussion with the woman should take place regarding any value of examining the placenta. If this is requested, an AlderHey form should be completed and the placenta should be placed in fixative in a white labelled container. Genetic testing of the placenta should be discussed and if the woman wishes to proceed with this a genetics request form should be completed and signed by both doctor and woman. The placenta should NOT be placed in fixative but sent DRY to the lab with the genetics forms.

12. There are no routine investigations required in TOP beyond a Group and Hold and Full Blood Count. Often investigations will have been performed antenatally. The clinical situation will dictate if any investigations are required e.g. cord blood for karyotype, maternal/placenta swabs for severe sepsis necessitating TOP. Please liaise with the medical staff regarding any additional tests required.
13. Women who are Rhesus negative should receive anti-D and have a Kleihauer test performed.

Care of the baby following delivery→

1. Ensure baby is clearly identified by 2 identification bands, checked by 2 members of staff
2. Baby should be dressed in clothing or wrapped in a blanket as per parental request, and this can be offered to the woman following transfer to the mortuary
3. Place baby in white coffin for transfer to mortuary when parents ready for discharge. Please liaise with the mortuary regarding paperwork completion and transfer.
Telephone number: 02837560220
4. Complete a 'body transfer' form to permit baby to be transferred to the mortuary
5. If parents decide they wish the baby to be cremated on hospital site, the baby remains in the mortuary until this is organised
6. If the parents decide they wish for private burial or funeral, the baby should be released to the family or the private funeral director (via the mortuary).

Discharge Planning→

1. Complete postnatal discharge checklist in regional hand-held maternity notes
2. Community midwife contacted by telephone and NIMATs labour summary and discharge forwarded to same
3. Check maternal consent to inform GP of Termination of pregnancy - forward NIMATS labour summary and discharge information to same
4. Ensure all other pregnancy related appointments are cancelled – complete cancellation of appts proforma.
5. Offer review appointment with to discuss results of any investigations including post-mortem

CAH and DHH – postnatal debrief clinic ,Dromore

6. Ensure the woman is aware of telephone numbers for maternity assessment unit in case of any postnatal complications.
 - a. CAH – 028 3756 1830 / 028 3756 1831
 - b. DHH – 028 3756 2730 / 028 3756 2788
7. The CMO will be informed of the TOP by the medical practitioner providing the termination within 14 days
8. Ensure parents have been given copies of relevant documentation- stillbirth or death certificate, copy of PM consent, discharge letter and copy of NIMATs.

Bereavement Support

Women who are undergoing a termination of pregnancy, for any indication, should be offered bereavement support, a memory pack and 'remembrance' photography.

Contact

Email: bereavement.midwives@southerntrust.hscni.net

A postnatal debrief should be offered following a termination of pregnancy.

- CAH – email Sharon Fox for postnatal debrief appointment
- DHH – email consultant's secretary

Conscientious Objection

The legal framework in Northern Ireland regarding conscientious objection mirrors the statutory protection set out by the UK Abortion Act 1967. Thus, no person is required, whether by contract or by any statutory/legal requirement, to participate in any treatment authorised by the regulations to which the person has a conscientious objection. The exception to this is when participation is necessary to save the life of the pregnant woman or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

The parameters set by the Supreme Court states that the extent of conscientious objection is restricted to the performance of the tasks involved in the **treatment** which brings about the termination of the pregnancy. This begins with the administration of the drugs designed to induce labour and ends with the delivery of the fetus, placenta and membranes. People carrying out ancillary, administrative and managerial tasks that are associated with those acts do not have the same right to conscientious objection. **For example- provision of basic needs- food, water, hygiene is not applicable to 'conscientious objection'.**

In addition, refusal to participate in paperwork or administration connected with abortion procedures thus lies outside the terms of conscientious objection.

Professional guidance such as the General Medical Council's (GMC) guidance on 'personal beliefs and medical practice' respects any individual practitioner's right to object to active participation in abortion, but highlights that care should not be obstructed. Thus, when a practitioner objects to performing or participating in a procedure, he/she must refer the person to a medical professional who can meet the patient's needs.

Counselling Checklist



Pregnancy Concerns: _____

Interpreter required: N/A / Yes: Language _____

- Diagnosis** appears understood by parent(s)
- Offered Neonatology review to further discuss diagnosis (provide info leaflet) _____
- Offered referral to bereavement midwives for support
- Offered more time if wishes to consider decision
- Pregnancy choices discussed including:

- **Continuing the pregnancy**

Care Offered
Care through Day Obstetric Unit with regular scans
Pregnancy support with specialist midwives
Neonatal care and hospice involvement(for life limiting anomalies)
Potential for time with baby if born alive including memory making (for lethal anomalies)
Risk of intrauterine death

- **Termination of pregnancy- medical and surgical methods discussed including side effects/risks of treatment**

Medical TOP	Surgical TOP (not currently available in NI >13wks)
10% nausea, vomiting or diarrhoea	10% nausea, vomiting or diarrhoea
13% retained tissue or incomplete procedure requiring surgical management	3% retained tissue or incomplete procedure necessitating repeat surgical management
1-10% have a severe bleed	1-10% have a severe bleed
Infection	Infection
Risk of uterine rupture if VBAC	Injury to uterus or cervix

- Clear wish for termination of pregnancy expressed
- No coercion suspected regarding decision making
- Discussed possibility of fetus being born with signs of life, necessitating doctor review. Offer referral to tertiary centre for feticide if gestation >21+6 weeks.
 - Certificate completed

Grounds for Termination of Pregnancy: **A / B / C / D / E / F / G** (please circle)

Doctor: _____
 Signature: _____
 GMC No. _____
 Date: _____

Doctor: _____
 Signature: _____
 GMC No. _____
 Date: _____

Termination of Pregnancy

Summary of Care

Date of Admission	
Admitting Midwife	
Parity/ Previous Modes of Delivery	
Gestation and EDC	
Presenting Maternal and Fetal history	
Medical Review and Plan	
Investigations to be requested	
Postnatal review	

Termination of Pregnancy Pathway

Care and Support on Admission	Yes	No	Signature
Suitable side ward available for the woman and her partner			
Parents are given the opportunity to speak with a senior obstetrician on admission			
The woman is supported by a dedicated midwife			

Discussion and information on the care choices available	Yes	No	Signature
Discussion regarding procedure for medical TOP			
Analgesia options and delivery discussed & prescribed			
Consent for further investigations (if applicable/ requested by medical team)			
Discussion regarding special or spiritual requests			
Discussion regarding seeing and holding baby after delivery			
Offer Post mortem information leaflet & video resources (Appendix 4)			

Record Timing of Mifepristone and Misoprostol doses

Drug and route	Date and time of administration

Termination of Pregnancy

Description of Baby at delivery

To be completed by the Obstetric Registrar or Midwife

Weight	
Face	
Hands	
Trunk	
Genitals	
Limbs	
Back	
Maceration	
Positional deformities	
Placenta	
Comments	

Termination of Pregnancy Pathway

Postnatal Care Action	Yes	No	N/A	Signature
Postnatal check and observations				
Placenta checked for completeness				
Lactation discussed including option of milk donation - Cabergoline 1mg PO STAT offered for suppression of lactation where appropriate				
Provide tea/toast for the woman and partner				
Moses basket available beside the woman's bed with use of cooling blanket				
Label the baby with 2 name-bands (can attach to cord clamp if baby too small for ID bands)				
Offer memory pack with cot card, foot/hand print and name-bands				
Weight of baby recorded in notes				
Offer commemorative photographs				
Provide opportunity to discuss care with senior duty obstetrician				
Post mortem consent form to be completed with Registrar/Consultant (even if wishes no PM)				
Discuss cremation and burial options (see page 15)				
Consider sending placenta for regional histopathological examination with Alder-Hey form in labelled white container (with fixative agent)				
If not for Post- Mortem discuss genetic testing of placenta (Placenta to be sent DRY with genetics request form signed by mother and doctor)				
Offer inclusion of baby's name in book of remembrance				

Termination of Pregnancy

For postnatal review appointments, please give the woman's maternity record to the labour ward clerk who will request an appointment letter is sent to the patient. The woman's notes will then be given to the consultant's secretary

Care of baby	Yes	No	N/A	Signature
Baby clearly identified by 2 ID bands, checked by 2 members of staff				
Prior to transfer to the mortuary the sister in charge should check all documentation, baby labels and if the placenta is to be sent for histopathology				
Place baby in a white coffin for transfer to the mortuary				
The woman and her birth partner are agreeable for baby to transfer to mortuary				
Refer to Trust Policy ' <i>Policy for release of a Baby</i> '.				
If baby is not for Post Mortem, a release of remains form should be completed				
Inform the community midwife if the remains have been released directly to the family				
If body released to the family, staff should accompany the woman and her partner to the hospital exit				

Termination of Pregnancy Pathway



Cremation and Burial options

Family Arranged Cremation

The woman has chosen to have a cremation arranged by the family. The family may use a funeral director to help make these arrangements. **Mortuary staff** will arrange for a **Form H** to be completed and advise the woman on the arrangements for this.

A **Form I** should be completed by the doctor or midwife who has examined the baby following the TOP if a cremation is to be arranged. **Form F** is to be left blank. Forms should be photocopied and placed in the woman's notes. The original H, I and F forms should be sent to the mortuary.

Family Arranged Burial

The woman has chosen to arrange a burial- the funeral director will usually help to make these arrangements.

Hospital Arranged Cremation

If woman chooses to have a hospital directed cremation, the family cannot attend the crematorium. Ashes can be collected from Roselawn Cemetery if parents wish to collect.

Form H is completed by the Mortician

Form I is completed by the doctor or midwife who has examined the baby following the TOP. **Form F** is to be left blank. Forms should be photocopied and the copy placed in the woman's notes. The original H, I and F forms should be sent to the mortuary.

Hospital Arranged Burial is not available in the Southern Trust

Termination of Pregnancy



Termination of Pregnancy- Documentation Checklist

Document	Completed	N/A
Discuss with coroner if signs of life at any gestation or stillborn >24wks Complete coroner's summary. <i>Appendix 4</i>		
NIMATS delivery summary		
Complete Labour Ward Register and TOP register		
If the fetus is born alive, a death certificate should be completed on NIECR		
If the fetus is born with no signs of life, a stillborn certificate should be completed if >24 weeks		
Post-Mortem Examination of a Baby form (to be completed even if PM is declined)		
If placenta for Histopathology Alderhey Request Form for placental examination (placenta in formalin)		
If placenta for genetics – genetic request form (placenta dry)		
Infant Cremation Form if family cremation planned		
Body Transfer Form		
Email Notification for CMO within 14 days (send copy to Nicola-ann.henderson@southerntrust.hscni.net)	Completed by _____	

Termination of Pregnancy

Appendix 1

Guideline for the Management of Live-born Babies after Termination of Pregnancy

Antenatal Counselling

A meeting with a senior paediatrician could be arranged for any mother whose baby has been identified as having a potentially lethal abnormality in order to assist the mother to make an informed decision about her options. In particular the mother should be informed of palliative care and an advanced care plan for her baby if she should choose to continue with her pregnancy. If such a meeting is requested it should take place in a pre-planned, elective manner.

Once the mother has made a decision to terminate her pregnancy, a paediatrician should not become involved and the obstetric and midwifery team manage all aspects of care to mother and baby.

All mothers choosing to terminate her pregnancy should be made aware of the possibility that the baby may be live-born and show signs of life such as breathing, moving and crying. The later the gestation the more likely the baby will be live-born. The baby may live for some time after delivery before passing away.

At Time of Birth

Babies showing any signs of life after being born after termination of pregnancy are persons and therefore need to be treated with dignity and prevented from suffering. The following measures should be taken to provide comfort:

1. If the mother is willing then the baby could be placed on her chest for “skin-to-skin” care.
2. The baby should be wrapped.
3. If the baby appeared distressed, they could be given a preterm soother.
4. If they continue to be distressed the baby could be given 0.5 – 1 mL 24% sucrose orally.
5. As the baby becomes acidotic because of hypoxia they are likely to gasp.
6. If the baby is considered to have a significant degree of distressed then the baby could be given morphine (100 micrograms/kg). This could be given orally as the oral solution should be absorbed from the buccal membranes or by subcutaneous injection of the IV solution.

Gestational Age	Dose of Morphine
18 to 21 ⁺⁶ weeks	40 micrograms
22 to 23 ⁺⁶ weeks	50 micrograms
24 weeks	60 micrograms

After death

All babies born with signs of life following termination of pregnancy must be discussed with the coroner. A medical certificate of cause of death will need to be completed by an obstetric doctor who has seen the baby alive. The coroner will advise on what the cause of death should be given as – a suggestion is 1a Medically indicated Termination of

Pregnancy

1b details of anomaly

If a doctor has not seen a live-born baby before death then the coroner needs to be informed and they will provide a “note in lieu”.

Termination of Pregnancy

Appendix 2

Signs of life guidance

Until specific guidance is available for determination of signs of life following termination of pregnancy it is recommended that MBRRACE-UK guidance for 'determination of signs of life following spontaneous birth before 24+0 weeks of gestation' is followed

Termination of Pregnancy

Appendix 3

Deciding on a Post Mortem

Video Resources

The Health and Social Care Board (HSCB) and Public Health Agency (PHA) have been working very closely with bereaved families, staff, charities and other partners to ensure that any baby or child who requires a post mortem is treated with the utmost respect, dignity and sensitivity throughout their journey now and in the future, and to ensure that families are fully supported when facing these very traumatic circumstances.

The HSCB and PHA have produced a short animated presentation to support parents make the difficult choice regarding a post mortem for their baby or child. They have also produced a video which introduces some of the staff who will be caring for them. Both have been co-produced by bereaved parents together with HSC staff and local charities which provide compassionate support for families. The HSCB extends special thanks to all of the parents who were involved in this process whom very kindly shared the experience of their own journey.

Determination of signs of life following spontaneous birth before 24⁺⁰ weeks of gestational age where, following discussion with the parents, active survival-focused care is not appropriate

MBRRACE-UK | Royal College of Obstetricians and Gynaecologists | British Association of Perinatal Medicine | Society of Paediatricians | Sands | ARC

NOTE: This guidance is only for births where following discussion with the parents, active survival-focused care is not appropriate. For decision-making relating to perinatal care and preterm delivery see British Association of Perinatal Medicine Framework for Practice for Perinatal Management at less than 27⁺⁰ weeks of gestation <https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019>.

Births INCLUDED in this guidance

- In-hospital spontaneous births <22⁺⁰ weeks
- In-hospital spontaneous births at 22⁺⁰ to 23⁺⁶ weeks where, following discussion and agreement with parents, active survival-focused care is not appropriate
- The same principles also apply to pre-hospital spontaneous births <22+0 weeks - see BAPM framework for practice on pre-hospital management of the baby born at extreme preterm gestation <https://www.bapm.org/resources/pre-hospital-management-of-the-baby-born-at-extreme-preterm-gestation>

Births EXCLUDED from this guidance

- Medical terminations of pregnancy
- Spontaneous births of uncertain gestation
- Spontaneous births at 22⁺⁰ to 23⁺⁶ weeks of gestation where initiation of active survival-focused neonatal care is planned or uncertain

Communication with parents

Effective communication can reduce the impact of trauma on parents. Sensitive counsel parents that:

- Babies born before 24 weeks are small and immature and often do not survive birth.
- Babies who die just before birth may show brief reflex movements but these are not 'signs of life'.
- Babies who survive birth may show signs of life for a few minutes or occasionally for a few hours. A doctor will be asked to attend to confirm signs of life and appropriate comfort care will be provided for their baby.

Actively listen and take the lead from the woman and her partner regarding preferred language. Many prefer to be described as 'parents' experiencing the 'loss' or 'death of their baby'. However each situation is unique and there are those who would prefer to be addressed as individuals rather than parents and for the birth to be referred to as 'the end of the pregnancy' or as a 'miscarriage'.

Observing signs of life

- Observe for visible persistent signs respectfully while holding baby
- Use of a stethoscope is not necessary
- Parents' observations of signs of life should be included in discussions if they wish to share them

Live birth is determined by 1 or more persistent visible sign of life:

- easily visible heartbeat
- definite movement of arms and legs
- breathing, crying or sustained gasps
- visible cord pulsation

Fleeting reflex activity including transient gasps, brief visible pulsation of the chest wall or brief twitches or involuntary muscle movement observed only in the 1st minute after birth does not warrant classification as signs of life.

Following live birth

England, Wales & Northern Ireland: A doctor should be called (usually the attending obstetrician) to confirm and document live birth. This avoids potential distress when the doctor cannot complete a death certificate because they have not seen the baby alive and there is then a requirement to contact the coroner.

Scotland: A doctor can rely on an attending midwife's history to confirm live birth and is not required to attend

UK-wide: Provide appropriate comfort care following a perinatal palliative care pathway. Care should meet baby's physical needs and parents' physical and emotional needs. See "Together for Short Lives" (<https://www.togetherforshortlives.org.uk/>).

Bereavement care: ALL BIRTHS

- Ensure a parent-led bereavement care plan is in place. Follow the National Bereavement Care Pathway in England (<http://www.nbcpathway.org.uk/>) and Scotland (<https://www.nbcp.scotland.org.uk/>) and locally developed bereavement pathways in Wales and Northern Ireland.
- Be aware of what choices your hospital can offer.
- Allow time for parents to decide what is right for them.
- Be sensitive to the individual needs of parents.
- Provide choices and support including time and privacy with baby, opportunities to make memories and discuss available options for burial, cremation or sensitive disposal of their baby's body.
- Inform parents about available support services and refer as appropriate.
- Refer parents as appropriate to community postnatal care, GP and mental health teams following local protocols.

Documenting the birth and death

MISCARRIAGE

UK-wide: Document the miscarriage. There is no legal requirement to register births before 24⁺⁰ weeks but sensitively offer parents informal 'certificate of loss' or 'certificate of birth'.

LIVE BIRTH

England, Wales & Northern Ireland: After the baby dies, a neonatal death certificate must be issued by a doctor who witnessed the signs of life. If signs of life have not been witnessed by a doctor, the doctor & midwife should confirm and document the live birth and the doctor must inform the coroner to issue a neonatal death certificate.

Scotland: The doctor and midwife should confirm and document the live birth. The doctor must complete a neonatal death certificate after the baby dies.

UK-wide: Complete birth notification. Parents must register the birth and death.

For further detail see www.npeu.ox.ac.uk/mbrrace-uk/signs-of-life

To view the presentation and video please scan the QR code:

<http://www.hscboard.hscni.net/our-work/commissioning/perinatal-and-paediatricpathology/>



Post Mortem Information Leaflet

The regional information booklet on Post Mortem can be viewed here To view the booklet please scan the QR code:

<https://hscbereavementnetwork.hscni.net/wp-content/uploads/2019/02/Hospital-PostMortem-Examination-of-Baby-or-Child-under-16.pdf>



If you have difficulty accessing these resources please contact a member of staff.

Record of Coroner's Discussion

Maternal ID sticker		
Brief Summary of case		
Date & Time coroner's office contacted - & record if no reply or will phone back		
Record of final discussion		
Outcome	SB/Death certificate to be issued	
	Coroner to issue death certificate with summary	
	Coroners case	
If SB/Death cert issued – cause of death	la	
	lb	
	lc	
	ll	
Coroners reference number		
Signature		
Print name		
Designation		
Date & time		

