

## Executive Summary

Dispatches has investigated how NHS Trusts and Boards across England and Wales treat the remains of babies who pass away during the early stages of pregnancy.

We have discovered that 27 Trusts and Boards incinerate thousands of remains every year.

Ten of those incinerate remains "as clinical waste".

We also have evidence that three Trusts are disposing of remains in "waste-to-energy" incinerators which provide power to hospitals.

Incineration of fetal remains has been banned in Scotland since July 2012. Many of the experts and mothers we have spoken to during the course of this investigation would like a similar ban for England and Wales.

Dispatches has also obtained documents provided to mothers experiencing pregnancy loss at hospitals that incinerate remains. These appear to contain inconsistent guidance by stating they "cremate" while our investigation found they incinerate.

Furthermore, we have looked at the practice of group cremation as a means of disposal. We have discovered Trusts cremating vast numbers, in excess of 300 sets of remains at a time, which many feel lacks the dignity such a service should provide.

## Background

There is no uniform guidance on how remains from early pregnancy loss should be disposed of.

Some hospital Trusts have told us they adhere to guidance set out in a Department of Health Executive Letter, EL(91) 144, from December 1991<sup>1</sup>.

Point 3 of EL(91) 144 states:

*"It is important that hospital authorities take account as far as possible of any personal wishes which have been expressed about disposal. In the case of incineration a further basic requirement use of separate containers for fetal tissue, separate delivery to the incinerator and separate loading. One way of determining whether current arrangements are satisfactory might be to ask health professionals whether they would feel able to answer parents' questions about the method of disposal without causing distress."*

In 2001 the Royal College of Nursing (RCN) undertook a review of current practices and issued guidelines ('Sensitive disposal of all fetal remains – Guidance for nurses and midwives'<sup>2</sup>).

They stated that the "minimum requirements" as described in the previous Department of Health guidance is "impossible with modern incinerators".

The RCN guidance strongly condemns incineration of fetal remains as clinical waste, and states the only acceptable means of disposal are cremation and burial.

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<sup>1</sup> Please see Appendix A for a copy of EL(91) 144

<sup>2</sup> Please see Appendix B for a copy of Sensitive disposal of all fetal remains – Guidance for nurses and midwives

# Channel 4 Dispatches

The document states:

*"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 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...."*

*"The following options should be available for disposing fetal remains: Hospital burial or cremation...private burial or cremation...burial outside a cemetery."*

However 13 years after this guidance was first published, the practice of incineration continues.

Furthermore, Human Tissue Authority Code of Practice 5<sup>3</sup> (last revised 2009) states in Point 115:

*"Fetal tissue from a pregnancy lost before 24 weeks may be incinerated, although how appropriate this is depends on the individual circumstances. Further guidance on incineration is available in the Royal College of Nursing guidance document on Sensitive disposal of all fetal remains."*

As we have seen, the RCN which is referred to, is opposed to incineration.

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<sup>3</sup> Please see Appendix C for a copy of HTA Code of Practice 5

## Scotland

In Scotland incineration is banned.

Following a review of practices Scotland's Chief Medical Officer, Sir Harry Burns, issued directorate SGHD/CMO(2012)7 in July 2012 stating "disposal of any pregnancy losses by way of incineration or clinical waste is no longer considered acceptable"<sup>4</sup>.

The guidance is categorical, and applies to all fetal remains regardless of gestational age.

Point 2 of the document states:

*"This guidance refers to disposal of all pregnancy loss up to and including twenty-three weeks and six days gestation, irrespective of cause or origin, where no signs of life have been detected following the loss, and whether or not fetal tissue can be identified."*

And point 4 definitively adds:

*"In recognition of the sensitivity around early pregnancy loss, disposal of any pregnancy loss by way of incineration or clinical waste is no longer considered acceptable."*

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<sup>4</sup> Please see Appendix D for a copy of Directorate SGHD/CMO(2012)7

## Trusts which Incinerate

We submitted Freedom of Information (FOI) requests to all of the acute NHS Trusts in England and Local Health Boards in Wales asking how they deal with remains of pregnancy loss.

The results showed a varied approach.

A total of 27 Trusts and Boards admitted to incinerating fetal remains<sup>5</sup>.

Information obtained from them revealed they had incinerated a total of 15,559 sets of remains in the two years from 2011 to 2013.

However the true figure is expected to be much higher as eight of those 27 refused to give us their actual numbers, only choosing to confirm that they do incinerate.

The 27 Trusts and Boards who admitted incineration during that time period are:

Birmingham Women's NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Cardiff and Vale University Health Board

Colchester Hospital-University NHS Foundation Trust

Epsom and St Helier University Hospitals NHS Trust

Great Ormond Street Hospital for Children NHS Foundation Trust

Hampshire Hospitals NHS Foundation Trust<sup>6</sup>

<sup>5</sup> Please see Appendix E for copies of the FOI responses from the 27 Trusts and Boards which incinerate

<sup>6</sup> As of 2013 Hampshire Hospitals NHS Foundation Trust no longer incinerates fetal remains. The trust ensures that all remains are now subject to individual cremation unless otherwise specified by the family. This incineration took place prior to the Trust wide agreement to stop the disposal of pre-24 week fetus' in this way

# Channel 4 Dispatches

Homerton University Hospital NHS Foundation Trust  
Kettering General Hospital NHS Foundation Trust  
King's College Hospital NHS Foundation Trust  
Kingston Hospital NHS Foundation Trust  
Leeds Teaching Hospitals NHS Trust  
Liverpool Women's NHS Foundation Trust  
Northampton General Hospital NHS Trust  
Oxford University Hospitals NHS Trust  
Plymouth Hospitals NHS Trust  
Royal Berkshire NHS Foundation Trust  
Royal Devon and Exeter NHS Foundation Trust  
Royal Free London NHS Foundation Trust  
Royal Surrey County NHS Foundation Trust  
Salisbury NHS Foundation Trust  
South Devon Healthcare NHS Foundation Trust  
South Warwickshire NHS Foundation Trust  
The Newcastle Upon Tyne Hospitals NHS Foundation Trust  
University Hospital Of South Manchester NHS Foundation Trust  
University Hospitals Coventry and Warwickshire NHS Trust  
Wye Valley NHS Trust

## Trusts which Incinerate as Clinical Waste

Of the 27 Trusts and Boards across England and Wales which incinerate fetal remains, ten also admitted to incinerating as clinical waste<sup>7</sup>.

Under the FOI requests those Trusts revealed they had incinerated 1,199 sets of remains as clinical waste in the two years from 2011 to 2013.

Again the true figure is expected to be much higher as four of those ten refused to give us their actual numbers.

The ten Trusts incinerating fetal remains as clinical waste during that time period are:

Great Ormond Street Hospital for Children NHS Foundation Trust

Kettering General Hospital NHS Foundation Trust

King's College Hospital NHS Foundation Trust

Kingston Hospital NHS Foundation Trust

Royal Free London NHS Foundation Trust

Royal Surrey County NHS Foundation Trust

Salisbury NHS Foundation Trust

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

University Hospital Of South Manchester NHS Foundation Trust

University Hospitals Coventry and Warwickshire NHS Trust

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<sup>7</sup> Please see Appendix F for copies of the FOI responses from ten Trusts which incinerate as clinical waste

## Waste-to-Energy Incineration

Our research revealed that three Trusts incinerate fetal remains at “waste-to-energy” incinerators.

The energy generated during incineration is in turn used to provide heat and power to the hospitals.

Those trusts are:

Cambridge University Hospitals NHS Foundation Trust which utilises its own incinerator<sup>8</sup>.

Colchester Hospital University NHS Foundation Trust, which sends its fetal remains to be incinerated at Ipswich Hospital<sup>9</sup>. The energy in turn provides power to Ipswich Hospital.

Salisbury NHS Foundation Trust, which sends its fetal remains to be incinerated at the Royal Bournemouth Hospital<sup>10</sup>, in a waste-to-energy facility.

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<sup>8</sup> Please see Appendix G for evidence of Cambridge University Hospitals NHS Foundation Trust’s waste-to-energy incinerator

<sup>9</sup> Please see Appendix H for evidence of Ipswich Hospital’s waste-to-energy incinerator

<sup>10</sup> Please see Appendix I for evidence of Bournemouth Hospital’s waste-to-energy incinerator

## Misleading Guidance

Through the course of our investigation we discovered two Trusts that appear to provide inconsistent guidance.

The first is Cambridge University Hospitals NHS Foundation Trust.

In each of the consent forms for the varying procedures relating to miscarriage and termination at Cambridge University Hospital NHS Foundation Trust (excluding those for home procedures) the following paragraph is included:

*"Fetal remains below 13 weeks gestation are cremated within the hospital, in accordance with the relevant code of practice. This is planned and organised to ensure that no other material is dealt with at the same time. The process is witnessed by two members of the bereavement team."*<sup>11</sup>

This appears inconsistent with the information obtained from our FOI responses stating that remains are incinerated.

This is in complete contradiction to the SANDS guidance on this point, which states:

*"If fetal remains will be incinerated rather than cremated, parents should be sensitively informed in the written information they are given that:- The method of disposal will be incineration (which must not be called cremation)."*<sup>12</sup> *is there a literal difference in the meanings of the words?*

Similarly, Northampton General Hospital NHS Trust uses the following statement on their disposal of fetal remains consent forms:

<sup>11</sup> Please see Appendix J for copies of these consent forms

<sup>12</sup> SANDS: Pregnancy Loss and the Death of a Baby: Guidelines for professionals 2007, p190

# Channel 4 Dispatches

*"If fetal remains are below 11 weeks, 6 days...I consent to the hospitals standard procedure for cremation and I understand that the ashes cannot be returned to me"*<sup>13</sup>

And information leaflets accompanying the consent forms provided to women experiencing pregnancy loss, contain the following paragraph:

*"Fetal remains under 11 weeks, 6 days gestation are cremated in a sensitive manor, in accordance with the relevant codes of practices.. This process is planned and organised to ensure that no other material is dealt with at the same time. Any ashes from this process cannot be returned to you."*<sup>14</sup>

However the Freedom of Information return from Northampton General Hospital NHS Trust states:

*"The number of fetal remains that were processed and incinerated through the Pathology department at NGH is as follows:*

*2011 - 323*

*2012 - 610*

*2013 to date - 338*

*These fetal remains were incinerated individually offsite in accordance with relevant codes of practice."*

<sup>13</sup> Obstetrics & Gynaecology Directorate: Consent Form – Disposal of Fetal Remains. Please see Appendix K for a copy.

<sup>14</sup> Obstetrics & Gynaecology: Patient Information – Medical management of miscarriage 2012. Please see Appendix K for a copy.

## Mass Cremations

Many NHS Trusts and Boards across England and Wales cremate the remains from pregnancy loss in small groups.

This is in keeping with the RCN guidelines and, as we have discovered through various interviews with senior midwives and bereaved parents, often a comfort to families who find solace in the idea of their child not being alone.

However, we have discovered Trusts cremating remains on such scale that it raises questions of appropriateness, with one example in excess of 300.

Included in the largest scale cremations are<sup>15</sup>:

Sheffield Teaching Hospitals NHS Foundation Trust cremates up to 302 sets of remains at a time

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust cremates up to 214 sets of remains at a time

East and North Hertfordshire NHS Trust cremates up to 120 sets of remains at a time

The Ipswich Hospital NHS Trust cremates up to 108 sets of remains at a time

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<sup>15</sup> Please see Appendix L for copies of these FOI requests

HINF 21/1558

I



PQ 688/1991/92  
Deposited Papers Clerk  
The Library  
House of Lords  
LONDON SW1

19 December 1991

Dear Sir,

EL(91)144  
SENSITIVE DISPOSAL OF THE DEAD FETUS AND FETAL TISSUE

I enclose two copies of the above for deposit in the Library  
with a copy of the relevant Parliamentary Question.

Yours faithfully,

A handwritten signature in black ink, appearing to be 'Richard Raynor', written over a horizontal line.

Richard Raynor  
Parliamentary Branch  
Department of Health  
071-210-5179

HINF 91/1558

Thursday 12 December 1991  
Written Answer

PQ 688/1991/92  
Han Ref: Vol 200  
Col 484-485

**DISPOSAL OF DEAD FETUSES**

136 Mr Alistair Burt (C. Bury North):

To ask the Secretary of State for Health, what advice is given to hospital authorities about the disposal of dead fetuses; and if he will make a statement.

MRS VIRGINIA BOTTONLEY

The NHS Management Executive will be issuing an Executive Letter (EL) to all General Managers and Chief Executives in the NHS about the disposal of dead fetuses. A copy of the letter will be placed in the Library.

Some hospitals are known to deal with these matters with understanding and sensitivity. The Government want all hospitals to apply standards of good practice, acceptable both to those personally involved, such as the parents, and to the hospital staff.

The ethical position guiding the Government's thinking is the acknowledgement that there is a respect due to the dead fetus which is based upon its lost potential for development into a fully-formed human being. That respect is due no matter what the circumstances of the loss (ie stillbirth, miscarriage or termination of pregnancy). That respect needs to be reflected as far as is practicable, in the arrangements for the disposal of the dead fetus.

The NHS Management Executive will be asking hospital managers to satisfy themselves that current arrangements are acceptable. It is important that as far as possible account is taken of any personal wishes which have been expressed about disposal. Subject to that incineration of the dead fetus is the usual method of disposal.

(Cont'd)

Where no special arrangements are called for it will, in any event, be a basic requirement that separate containers are used for fetal tissue, that the containers are delivered to the incinerator separately from any other material requiring incineration and are separately loaded into the incinerator.

Some concern has been expressed about the position of ancillary staff in relation to the handling of fetuses and fetal tissue following the termination of pregnancy. Such staff are not covered by the provisions of Section 4 of the Abortion Act 1967 - the "Conscience Clause" - which acknowledges conscientious objection to participation in treatment authorised by the Act. However the Government believe that hospital managers will wish to ensure that the same principle is applied to any ancillary staff who express a conscientious objection to the handling of fetuses or fetal material. The issues covered in this statement will form the basis of the Executive Letter to General Managers and Chief Executives. Copies will also go to relevant private hospitals.

# NHS Management Executive

To: Unit General Managers  
SHA General Managers  
NHS Trust Chief Executives

Copy: Regional General Managers  
District General Managers  
FHSA General Managers

Department of Health  
Richmond House  
79 Whitehall  
London SW1A 2NS  
Telephone 071-210 3000

**EL(91)144**

12 December 1991

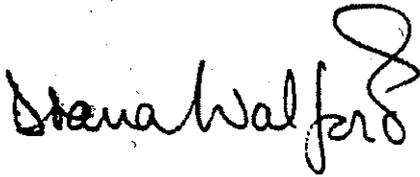
Dear Colleague,

## ***Sensitive disposal of the dead fetus and fetal tissue***

1. You will recall the statement by the Chief Executive to the press on 26 June 1991 on this subject in which he asked hospitals to act with special sensitivity when disposing of fetuses and fetal tissue. This letter contains further advice on the matter.
2. There is a respect due to the dead fetus which is based upon its lost potential for development into a fully-formed human being. That respect is due no matter what the circumstances of the loss (ie stillbirth, miscarriage or termination of pregnancy). With that important factor in mind, I should be grateful if you would satisfy yourself that current arrangements for disposing of fetuses and fetal tissue are acceptable.
3. It is important that hospital authorities take account as far as possible of any personal wishes which have been expressed about disposal. In the case of incineration a further basic requirement is the use of separate containers for fetal tissue, separate delivery to the incinerator and separate loading. One way of determining whether current arrangements are satisfactory might be to ask health professionals whether they would feel able to answer parents' questions about the method of disposal without causing distress.
4. Maternity Services Liaison Committees represent the views of a cross-section of professionals and users of services and will be a helpful source of advice on these matters. Advice can also be obtained from the following voluntary organisations: the Stillbirth and Neonatal Death Society (SANDS), the Miscarriage Association and Support After Termination for Fetal Abnormality (SATFA). The annex lists the addresses of the organisations' national bodies.
5. Finally, some concern has been expressed about the position of ancillary staff in relation to the handling of fetuses and fetal tissue following termination of pregnancy. Although such staff are not covered by the provisions of Section 4 of the Abortion Act 1967, which acknowledges conscientious objection to participation in *treatment* authorised by the Act, hospital managers will wish to ensure that the same principle is applied to any ancillary staff who express a conscientious objection to the handling of fetuses or fetal tissue.

6: Please address any enquiries about this letter to Mr J P Crook, Child Health, Maternity and Prevention Division 3, Room 404 Wellington House, 133-135 Waterloo Road, London SE1 8UG, Tel 071 972 2000 Ext 24194.

Yours sincerely,

A handwritten signature in cursive script that reads "Diana Walford". The signature is written in dark ink and is positioned in the middle-left area of the page.

Dr D Walford  
Director of Health Care/Medical Director  
NHS Management Executive

This letter will be reviewed in 1995

**National addresses of voluntary organisations concerned**

Stillbirth and Neonatal Death Society<sup>1</sup>  
28 Portland Place  
London  
WIN 4DE  
071-436 7940 (Administration)

The Miscarriage Association  
c/o Clayton Hospital  
Northgate  
Wakefield  
WF1 3JS  
0924-200795

Support After Termination for Fetal Abnormality  
29-30 Soho Square  
London  
W1V 6JB  
071-439 6124

<sup>1</sup> SANDS' *Guidelines for Professionals on Miscarriage, Stillbirth and Neonatal Death* were circulated to the service on 25 April this year.



Royal College  
of Nursing

# **Sensitive disposal of all fetal remains**

*Guidance for nurses and midwives*



Royal College  
of Nursing

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Members of the Working Group would like to  
acknowledge the help and support of colleagues in  
producing this document.

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# Sensitive disposal of all fetal remains

*Guidance for nurses and midwives*

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1

## 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.

2

## 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 to 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



## 3

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.

## Options available

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)

- ✦ 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).

## Suggestions to improve practice

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



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 this ..... day 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](mailto: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](mailto:comm@bpas.org)  
Web site: [www.bpas.org](http://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](mailto:admin@hfea.gov.uk)  
Web site: [www.hfea.gov.uk](http://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](mailto:enquiries@hta.gov.uk)  
Web site: [www.hta.gov.uk](http://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](http://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](http://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](mailto:support@uk-sands.org)  
Web site: [www.uk-sands.org](http://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](http://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](mailto: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](mailto:info@multiplebirths.org.uk)  
Web site: [www.multiplebirths.org.uk](http://www.multiplebirths.org.uk)

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The Multiple Births Foundation (1997) *Guidelines for professionals – bereavement*. London, The Multiple Births Foundation.

## Further reading

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# Human Tissue Authority

## Code of practice 5 Disposal of human tissue

### Section: Disposal following pregnancy loss

**September 2009**

An independent statutory regulator sponsored by  *Department of Health*

Note: Paragraph 73

Amended: February 2010

Effective date: 16 February 2010

Action: Establishments may consider whether action is required in line with paragraph 73

## Disposal following pregnancy loss

### Introduction

- 91.** This section is intended to help staff to develop or modify their establishment's policy on disposal following pregnancy loss. It aims to cover the main issues and suggests sources of further information.
- 92.** The advice within this section is suitable for developing policies on the disposal of fetal tissue resulting from a number of different pregnancy losses, including ectopic pregnancies, miscarriages, early intrauterine fetal deaths and termination of pregnancy. It is not recommended for patient information.
- 93.** The term 'fetal tissue' is used throughout for consistency in reference to cases of pregnancy loss before 24 weeks gestation, although it is recognised that pregnancy loss before 24 weeks covers many different kinds of loss.
- 94.** While the guidance within this section primarily refers to cases of pregnancy loss before 24 weeks gestation (see separate guidance on stillbirths and neonatal deaths in [paragraphs 118–121](#)).
- 95.** Please note the guidance does not apply to the following:
- i. unidentifiable stillbirths that have been stored for teaching or research
- See section on existing holdings ( [paragraphs 122–123](#) ) for advice on the disposal of existing holdings of fetal tissue and the bodies of stillborn babies.
- ii. embryos created in vitro, which are regulated under the Human Fertilisation and Embryology Act 2008  
[www.opsi.gov.uk/acts/acts2008/ukpga\\_20080022\\_en\\_1.htm](http://www.opsi.gov.uk/acts/acts2008/ukpga_20080022_en_1.htm)

### Development of disposal policy

- 96.** In drafting their policies, establishments may wish to take into account gestational age and the nature of the fetal tissue.
- 97.** It is recommended that disposal policies reflect handling of pregnancy loss and the needs of the woman or couple should be paramount in any policy development.
- 98.** Women or couples may seek information about the establishment's policy on the disposal of fetal tissue. It is therefore good practice for all staff involved in the process to be aware of policy and practice, and be prepared to discuss these issues.
- 99.** Detailed guidance on communication with women or couples regarding all areas of pregnancy loss may be found in the guidance from the Stillbirth and neonatal death society Pregnancy loss and the death of a baby: guidelines for professionals (hereafter referred to as Sands guidelines). It should be noted that this document is not available to view online but may be purchased through the Sands website [www.uk-sands.org](http://www.uk-sands.org)
- 100.** Additional guidance on the development of policy in this area is available in the Department of Health's document When a patient dies: advice on developing bereavement services in the NHS [www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Bereavement/index.htm](http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Bereavement/index.htm) , in the Royal College of Obstetricians and Gynaecologists' Good practice guidance No. 5 [www.rcog.org.uk/resources/public/pdf/goodpractice5.pdf](http://www.rcog.org.uk/resources/public/pdf/goodpractice5.pdf) and in the Department of Health, Social Services and Public Safety (DHSSPS) (Northern Ireland) guidance Careplan for women who experience a miscarriage, stillbirth or neonatal death [www.dhsspsni.gov.uk/hoi-careplan.pdf](http://www.dhsspsni.gov.uk/hoi-careplan.pdf) .
- 101.** Where terminations are carried out by independent sector clinics on behalf of NHS establishments, staff may wish to discuss issues relating to the disposal of fetal tissue with them.

### Storage of fetal tissue before disposal

- 102.** Fetuses and fetal tissue should be stored separately in secure containers in a safe place. Containers should be made from opaque materials and be fit for transporting the tissue.

### Handling of tissue

- 103.** A woman or couple should be made aware that information on disposal options is available if they wish to see it. When providing information, the language spoken and any communication difficulties should be taken into consideration.
- 104.** It should be clearly documented in the woman's medical notes whether or not information was requested and whether it was given.
- 105.** The information provided should explain who to contact to request a particular disposal option and the timescale for this. Any personal, religious or cultural needs relating to the disposal of the fetal tissue should be met wherever possible and documented in the woman's medical notes.

**106.** Staff should be aware of and sensitive to the values and beliefs of a wide range of cultures and religions, particularly those of their local community. They should also be aware that each decision is one for the individual concerned.

**107.** Establishments should ensure that the necessary training and support is given, so that employees are equipped to identify and meet the widest possible range of needs and wishes.

**108.** Some women or couples may not wish to know about the disposal of the fetal tissue. Providing they have been told that the information is available, their wishes should be respected.

**109.** In some cases, women or couples may not want to be involved in decisions about disposal of fetal tissue at the time, but then return later having changed their minds or asking about what arrangements were made. It is therefore important to ensure that as well as respecting the wishes of those who chose not to be involved at the time, the disposal of fetal tissue is carried out as outlined within this guidance. Records should clearly document how and when fetal tissue was disposed of in order that, if needed, full information may be provided at a later date.

**110.** A woman or couple may decide to arrange disposal themselves and they are free to do so. The Royal College of Nursing guidance document on Sensitive disposal of all fetal remains looks at the options available [www.rcn.org.uk/development/publications/publicationsA-Z#S](http://www.rcn.org.uk/development/publications/publicationsA-Z#S).

## **Disposal options (see Appendix A )**

### **Burial**

**111.** Fetal tissue may be buried providing there has been consultation with the woman or couple, where appropriate. Establishments wishing to bury fetal tissue should consult the local burial authorities to establish what level of service is available. If they wish to offer burial, and this service is not available locally, they might consider contacting other service providers further afield. Communal burial is permitted for fetal tissue.

**112.** A woman or a couple may bury fetal tissue at home if they wish, providing certain criteria have been fulfilled. The tissue should be supplied to them in a suitable opaque container. It may be necessary to contact local authorities to discuss this option.

### **Cremation**

**113.** Although not covered by The Cremation (England and Wales) Regulations 2008 [www.opsi.gov.uk/si/si2008/uksi\\_20082841\\_en\\_1](http://www.opsi.gov.uk/si/si2008/uksi_20082841_en_1) fetal tissue may be cremated, providing there has been consultation with the woman or couple where appropriate. Some crematoria are willing to provide a service to dispose of fetal tissue, but this is at their discretion. Establishments wishing to cremate fetal tissue will need to negotiate with the local crematoria to establish what level of service may be provided. If this service is not available locally, they might consider negotiating with other service providers further afield. Communal cremation for fetal tissue may be permitted by some crematoria.

**114.** Women or couples should be told that the cremation of fetal tissue does not often produce any ashes for them to scatter.

### **Incineration**

**115.** Fetal tissue from a pregnancy lost before 24 weeks may be incinerated, although how appropriate this is depends on the individual, circumstances. Further guidance on incineration is available in the Royal College of Nursing guidance document on Sensitive disposal of all fetal remains [www.rcn.org.uk/development/publications/publicationsA-Z#S](http://www.rcn.org.uk/development/publications/publicationsA-Z#S).

**116.** Women or couples should be made aware that information on disposal options is available, and consulted on, and given the opportunity to express, any personal wishes.

**117.** The maceration and sluicing method of disposal is not permitted for fetal tissue.

## **Stillbirths and neonatal deaths**

**118.** Babies born dead after 24 weeks gestation are defined under law as stillbirths and must be registered as such. Common law requires that stillbirths must be buried or cremated. Requirements for the disposal of stillbirths also apply in the case of terminations after 24 weeks gestation.

**119.** A baby or fetus of any gestational age which is born showing signs of life and dies before the age of 28 days is a live birth and neonatal death, and must be treated as such in terms of registration and disposal. The law requires that where a baby or fetus is born showing signs of life and then dies they must be buried or cremated.

**120.** While the legal duty to dispose of a stillbirth or neonatal death rests with the parents, with their consent, it may be done by establishments on their behalf. In respect of stillbirths, it has long been recognised as good practice for hospitals to offer to arrange and pay for burial or cremation. If parents would like this, they should be given the opportunity to attend the ceremony.

**121.** Further guidance on the requirements for the registration and disposal of stillbirths and neonatal deaths is available within the Sands guidelines <http://www.uk-sands.org/>. Guidance on consent may be found in the code of practice on Consent

## **Existing holdings**

The complete HTA code of practice 5 is available at [www.hla.gov.uk](http://www.hla.gov.uk)

**122.** Where existing holdings include stored fetuses and fetal tissue, establishments holding these samples will need to ask the same questions relating to their disposal (see paragraphs 57–85).

**123.** Where the holding is a whole body of a stillborn child, requirements for the disposal of stillbirths will apply, as outlined in paragraphs 118 and 120–121.

Directorate of Chief Medical Officer and Public Health

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DELIVERING  
A GAMES LEGACY FOR SCOTLAND

Dear Colleague

**DISPOSAL OF PREGNANCY LOSSES UP TO AND INCLUDING  
23 WEEKS AND 6 DAYS GESTATION**

1. The purpose of this letter is to provide revised guidance on the disposal of pregnancy losses up to and including 23 weeks and 6 days gestation, within NHS Scotland.

**Summary:**

2. The core guidance is attached as Annex A and is supported by a series of appendices which are attached as Annex B.

3. The guidance is based on the work of a multi-disciplinary working group and has been the subject of consultation with health boards and professional groups.

4. This guidance replaces the guidance given in SOHHD/DGM (1992)4. ("Sensitive Disposal of Fetuses and Fetal Tissue following Termination of Pregnancy")

**Action:**

5. Chief Executives of NHS Boards should ensure that the attached guidance is brought to the attention of all appropriate staff and that the proposed changes to procedures for the disposal of pregnancy losses up to 23 weeks and 6 days are implemented as soon as is practicable.

6. In particular, Chief Executives of NHS Boards should note that disposal of any pregnancy losses by way of incineration or clinical waste is no longer considered acceptable.

7. The Scottish Government will contact Health Boards after 12 months to audit compliance.

Yours sincerely

*Harry Burns*

**HARRY BURNS**

*Ros Moore*

**ROS MOORE**

From the Chief Medical Officer  
Chief Nursing Officer  
Sir Harry Burns MPH FRCS(Glas)  
FRCP(Ed) FFPH  
Ros Moore RGN, BSc (Hons) Nursing,  
MA

19 July 2012

SGHD/CMO(2012)7

**For Action**

Chief Executives, NHS Boards  
Directors of Nursing & Midwifery, NHS Boards  
Medical Directors, NHS Boards

**For Information**

Consultant Obstetricians  
Consultant Pathologists  
Royal College of Nursing  
Royal College of Midwives  
Heads of Midwifery  
Royal College of Obstetricians  
Royal College of Pathologists  
Institute of Cemetery and Cremation Managers  
Federation of Burial and Cremation  
Management  
Scottish Pathology Network  
Association of Anatomical Pathology  
Technology  
Chairs, NHS Boards  
Directors of Public Health, NHS Boards

**Further Enquiries**

**Policy Issues**

Alison Kerr  
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**Medical Issues**

Dr Catherine Calderwood  
2N, St Andrew's House  
[catherine.calderwood@scotland.gsi.gov.uk](mailto:catherine.calderwood@scotland.gsi.gov.uk)

## **GUIDANCE ON THE DISPOSAL OF PREGNANCY LOSSES UP TO AND INCLUDING 23 WEEKS AND 6 DAYS GESTATION**

1. This document updates the guidance given in SOHHD / DGM (1992) 4. ("Sensitive Disposal of Fetuses and Fetal Tissue following Termination of Pregnancy")
2. This guidance refers to disposal of all pregnancy loss up to and including twenty-three weeks and six days gestation, irrespective of cause or origin, where no signs of life have been detected following the loss, and whether or not fetal tissue can be identified.
3. This guidance does not refer to, or change, current procedures for the disposal of stillbirths occurring from twenty-four weeks and zero days gestation, nor does it change current procedures for the disposal of placentae.
4. In recognition of the sensitivity around early pregnancy loss<sup>1,2</sup>, disposal of any pregnancy loss by way of incineration or clinical waste is no longer considered acceptable.
5. This document outlines the minimum standard expected for the disposal by NHS Boards of all pregnancy losses, where the woman:
  - a) expresses a wish for the NHS Board to dispose of the pregnancy loss, or
  - b) declines to express any wish regarding disposal [see paragraph 7 (d)].

However, it is of course recognised that women have the right to make alternative personal arrangements.

### 6. Minimum standard for disposal:

The minimum standard is collective disposal in a crematorium. In circumstances where such disposal is not available, disposal by collective burial is acceptable. In either situation, "collective" is defined as a number of pregnancy losses, in individual sealed containers, collected together into a larger sealed container. (See Annex E)

### 7. Authorisation and opting out:

- a) Information on available options for disposal should be made available to all women who experience pregnancy loss. Notes on drafting an information leaflet, and an example from one Board is at Annex B.
- b) It is recommended that disposal should be authorised by the woman who has experienced the loss. An example of wording, which could be used as part of a consent form for a procedure or could be used as a stand-alone form, is at Annex C.
- c) Women may decline disposal by the NHS Board in favour of making their own arrangements. In this case, the pregnancy loss should be stored and made available for

<sup>1</sup> See RCOG Good Practice Guideline No 5 (2005);

<sup>2</sup> SANDS Pregnancy Loss and the death of a baby (2007);

collection by the woman or her agent. Such a decision must be recorded in the patient's notes.

d) Where authorisation for disposal, or declaration by a woman that she wishes to make alternative arrangements has not been received six weeks from the date of pregnancy loss, the NHS Board responsible for the woman's care at the time of the loss should, as a matter of good practice, proceed to make arrangements for disposal. Such an outcome must be recorded in the patient's notes.

#### 8. Religious, ethical and cultural issues:

Where a woman wishes, for reasons of religious, ethical, or cultural preference, or for other reasons, to make alternative arrangements for disposal of the pregnancy loss, it is appropriate for the NHS Board concerned to offer advice and assistance. Costs incurred in any alternative arrangement will normally be the responsibility of the family.

#### 9. Confidentiality:

In any communication with regard to collective disposal, to organisations outwith NHSScotland (such as crematoria), Boards should only identify a pregnancy loss by a unique disposal number, allocated for this purpose. Patient details, including Community Health Index Number, may not be shared outwith NHSScotland without express permission from the patient.

#### 10. Audit:

The responsibility for maintaining a record of the disposal rests with the NHS Board and this record should be retained for a **minimum** of 30 years. NHS Boards should develop clear processes for the management and retention of this record within their own local record management systems and in line with Scottish Government guidelines on record management and with the terms of the Data Protection Act 1988 and the Abortion Act 1967. A recommended data set for the NHS record is outlined in Annex D. A suggested form of application for collective disposal of pregnancy losses, agreed with the Institute of Cemetery and Crematorium Management, is included as Annex F.

#### 11. Timescales:

The disposal of a pregnancy loss should be arranged as soon as practicable, after authorisation is received.

#### 12. Sensitivity:

In all matters relating to the disposal of pregnancy loss it should be remembered that this is a highly sensitive issue. Language used in communicating with women and their families should reflect this. Arrangements should be in place to provide, or signpost to, appropriate support.

#### 13. Supporting documents:

Annexes accompany this guidance for information and advice only.

Annex A: Outline flowchart for decision making process

Annex B: Notes to aid development of local leaflets.

Annex C: Suggested wording for authorisation

Annex D: Recommended minimal data set for future audits

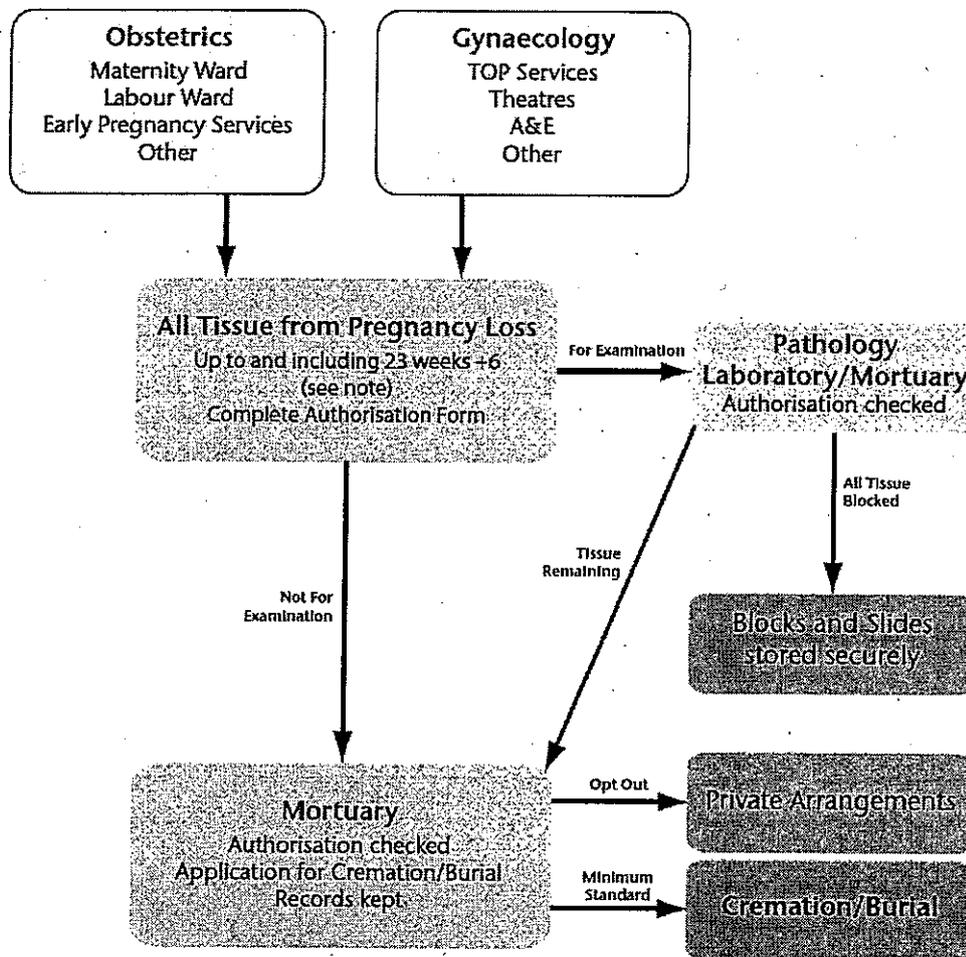
Annex E: Notes on packing and transportation of pregnancy losses

Annex F: Suggested application form for cremation of pregnancy losses

**Guidance on disposal of Pregnancy Loss up to and including 23 weeks and 6 days gestation**

**Flow Chart**

**Disposal of Pregnancy Loss**



**Note**

All tissue from a pregnancy loss including miscarriage, termination of pregnancy and ectopic pregnancy. Placentae where the fetus is separately identified and greater than 12 weeks gestation are not included.

Guidance on disposal of Pregnancy Loss up to and including 23 weeks and 6 days gestationNotes on drafting NHS Board Information leaflet for patients

**NOTE: This is for guidance only. Each Board will require to develop its own leaflets. Because of sensitivity of language, Boards are advised to develop two leaflets, one for women having terminations and one for miscarriages. All leaflets should be subject to the Board's own guidance on drafting and style. Examples are available from Boards currently using this system, such as NHS Ayrshire and Arran and NHS Tayside**

Heading	Notes	Example
Title	The title should be sensitive.	Arrangements following the loss of your pregnancy
Introduction	A clear statement of purpose,	The aim of this leaflet is to provide you with information about what happens to your baby. We use the term Pregnancy Loss to refer to losses at any stage from conception until 23 weeks and six days. After 24 weeks gestation different procedures are required by law. the policy of NHS XXX complies with the national guidelines for the sensitive disposal of pregnancy loss.
What happens?	The leaflet should probably refer to national guidance  Some simple basic description of the procedure. Note that some crematoria will not wish you to say where and when this takes place as they may not wish families to attend	The pregnancy loss will be placed in a small individual box. It will be looked after in the mortuary and then be taken to a local crematorium along with other pregnancy losses, each in their own container
Will there be any ashes?	Reassurance about dignity is important	Although a number of containers are transported and cremated together, be assured that each one is handled throughout the process with respect and dignity.
Is there a charge?	It is important to state that ashes will not be available. [This is because of the absence of formed bone].	There are no cremated remains (ashes) from this process.
		No. NHS XXX will pay for this service

<p><b>Can I go to the crematorium?</b></p>	<p>This will be by local arrangement. Some crematoria will allow and some will not. There is no point in attending unless there is to be some form of committal.</p> <p>If parents can attend, who will tell them when the committal will be? What if there is a delay for pathology?</p> <p>But there may be a local memorial garden</p>	<p>You may wish to be present at the crematorium for the committal. If you would like to attend, please tell your midwife or the nurse who is looking after you within XX hours/days.</p> <p>Sometimes there is a delay before cremation, for example, if you have agreed to tests or an examination of your baby. A midwife/ a funeral director / our bereavement office will contact you to confirm the date and time of the cremation.</p> <p>There is not a service at the crematorium, but there is a children's memorial garden which you can visit at any time.</p>
<p><b>Can I make my own arrangements?</b></p>	<p>The option to opt out is very important and might be actively encouraged for older gestations</p> <p>Remember there is a cost for this – unless the health board is paying</p>	<p><b>Yes.</b> You may wish to make alternative arrangements. These arrangements would need to be made privately. This private arrangement may be more appropriate to your needs, depending on the stage of your pregnancy. Private arrangements will ensure you have the type of service, cremation or burial that you prefer. To do this, you should contact a funeral director.</p> <p>Please be aware that you would have to pay the costs. The costs vary considerably between funeral directors and will depend on the arrangements and type of service you request</p>
<p><b>What if I cannot make a decision, or do not wish to make a decision</b></p>	<p>The guidance has a default clause that where there is no decision the Board should dispose of the loss after 6 weeks</p>	<p>You will understand that we cannot keep pregnancy loss in the mortuary indefinitely. If you have not indicated your choice to us after six weeks the NHS guidance allows us to make the decision and to arrange for your pregnancy loss to be taken to the crematorium</p>

Guidance on disposal of Pregnancy Loss up to and including 23 weeks and 6 days gestation

**Authorisation for sensitive disposal following pregnancy loss**

Addressograph label

**Disposal of pregnancy loss**

Complete either Section A or Section B. Delete whichever is not applicable

**Section A:**

The options for disposal have been explained to me Yes / No

I give authorisation for my pregnancy loss to be disposed of by the hospital in accordance with procedures outlined Yes / No

If no, please indicate if:

- 1) I have not yet decided, or
- 2) I will make my own arrangements through a funeral director, or
- 3) I wish to take my pregnancy loss out of the hospital (release of tissue form to be signed)

I understand that if I change my mind I must phone the hospital within [*time to be agreed locally*], Yes / No

**Section B:**

I have declined to discuss this matter and recognise that the hospital will proceed according to their standard procedure

Signature of the woman.....

Date Signed .....

Witness Signature.....

Witness name (Block Capitals) .....

Designation.....

**RELEASE OF PREGNANCY LOSS TO THE WOMAN**  
**(IF MAKING OWN ARRANGEMENTS)**

I would like to take my pregnancy loss home following my discharge from the unit.  
*[Note: further paperwork may be required, for example to acknowledge health and safety issues.]*

Ward.....

Name.....

Hospital number.....

Address.....

Signature of the woman.....

Name of the Consultant.....

Name of Nurse/Midwife completing form.....

Signature of the Nurse/Midwife.....

Date.....

Copy of form for case notes  
Copy for woman to take away  
Copy for pathology / mortuary

**Guidance on disposal of Pregnancy Loss up to and including 23 weeks and 6 days gestation**

**Recommended Dataset**

These data items are for use within NHSScotland only.

A unique disposal number, generated in the Hospital Mortuary or elsewhere, should be used to identify the pregnancy loss to any external bodies, such as funeral directors and crematoria in order to protect sensitive data and preserve anonymity. No other data should be shared.

Traceability for parents in any subsequent enquiry would be through NHS records. To support this, the data should be held for a minimum of 30 years, with good practice being retention for 50 years.

Scottish Government guidance on collective disposal states that each pregnancy loss should be placed in a separate container, and these small containers may then be placed together in a large container for collective disposal.

<b>Patient Information:</b>	Woman's name:
	CHI of woman
	Gestational age of pregnancy loss
	Date of procedure/delivery
	Consultant: / Midwife:
<b>Authorisation</b>	Name of person taking authorisation
	Date of authorisation
	Nature of authorisation:
	<ul style="list-style-type: none"><li>▪ Collective disposal</li><li>▪ Own arrangements</li><li>▪ Declined to specify</li></ul>

**Disposal Information:** Date received into mortuary

Type of Disposal:

- Collective disposal at crematorium
- Collective burial
- Individual disposal at crematorium
- Individual burial
- Removed by woman

Name of applicant for cremation / burial

Date of application for cremation / burial

Date left mortuary

Collected by:

- Funeral Director (Name and Company)
- Designated member of staff (Name and Designation)
- Woman or agent

**Identifiers:**

Unique disposal number (to be clearly marked on the small container and used in application for disposal)

Large container number (to be clearly marked on large container and used in application for disposal)

**Guidance on disposal of Pregnancy Loss up to and including 23 weeks and 6 days gestation**

**Packing and Transport**

Arrangements for packaging and transport of pregnancy losses to the mortuary or pathology laboratories should follow local guidance, which should ensure that the pregnancy loss is at all times handled with dignity and respect.

Following surgical termination, where the pregnancy loss is contained within an evacuation vessel such a vessel must be of a material which is acceptable to the crematorium. For transport and disposal, the evacuation vessel should be placed within a suitable opaque container. There is no requirement to separate tissue from other fluids.

Following all other losses, the pregnancy loss should be wrapped and sealed according to local policy, and placed in an opaque container, ensuring that any material used is acceptable to the crematorium.

Each pregnancy loss should be labelled according to local policy with the name, address and CHI number of the woman.

When disposal has been agreed, individual containers should then be allocated a unique disposal number for disposal, and be placed within a larger container for collective disposal.

The large container should be securely sealed and labelled with an identifying code. **No identifiable information should be visible.** Again all material used must meet the requirements of the crematorium.

Transport to the crematorium should be carried out in a discreet, and dignified fashion, either by a funeral director or by hospital transport.

All pregnancy losses should be handled with dignity, care and respect.



.....Post Code: .....

Dear Mr Basnett

FREEDOM OF INFORMATION ACT 2000

Further to my acknowledgement of 12 September 2013, the Trust has reviewed your request and is now able to respond as follows:

2 a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

- Products of Conception specimens that may contain fetal somatic tissue – the department records this type of information on the patient request form and the histology report. We handle around 800 POC cases per year. Only a small percentage of cases contain recognisable fetal body parts. If the requestor requires an accurate count then this will take 3 – 4 days' work looking through each and every request form. They will be billed accordingly for the time.
- Fetuses <16 weeks gestation – 48 cases
- Fetuses 16 – 24 weeks gestation – 56 cases through the hospital via cremation or burial as requested by the family

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

- Products of Conception specimens that may contain fetal somatic tissue – incinerated in groups by 'Respectful Disposal', Not together with clinical waste. Some cases returned to patient as for private arrangements.
- Fetuses <16 weeks gestation – Cremated in groups. Some cases returned to patient for private arrangements
- Fetuses 16 – 24 weeks gestation – Individual cremation or burial as requested by the family. Some cases returned to patient for private arrangements

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

- Products of Conception specimens that may contain fetal somatic tissue – incinerated in groups by 'Respectful Disposal', Not together with clinical waste – Collection through Inspire Healthcare Services & Disposal Contractor: SITA, Woodrow Drive, Redditch, Worcestershire, B98 7UB

2. a) b) and c) The same for 2011/12

- Products of Conception specimens that may contain fetal somatic tissue – the department records this type of information on the patient request form and the histology report. We handle around 800 POC cases per year. Only a small percentage of cases contain recognisable fetal body parts. If the requestor requires an accurate count then this will take 3 – 4 days' work looking through each and every request form. They will be billed accordingly for the time.
- Fetuses <16 weeks gestation – 63 cases
- Fetuses 16 – 24 weeks gestation – 44 cases. Note: Figures only from September 2011 to March 2012 as data recorded electronically in bereavement according to gestational age from this period. If figures required from April 2011 then this will require looking through paper documents. The requestor will billed accordingly for the time.
- Answers to 2 b) and c) same as answers to 1 b) and c).

I trust that the above is helpful. If however, you wish to complain about the handling of your request or the content of this reply, please do not hesitate to contact me again and I will try to assist further. It would be helpful if you could explain the reasons for your dissatisfaction and quote the above reference. Should local resolution fail, you may request an independent internal review and ultimately you may appeal to the Information Commissioner's Office at Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

FOI Team

Birmingham Women's NHS Foundation Trust

E-mail: [foi.team@bwhct.nhs.uk](mailto:foi.team@bwhct.nhs.uk)

FOI Customer Satisfaction Survey

So that we can improve our FOI service we would be grateful if you could please take a moment to complete our FOI Customer Satisfaction Survey by clicking on the link below. Please do not use this form to complain or for general enquires.

<http://www.surveymonkey.com/s/FOIBWH>

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The information contained in this e-mail may be subject to public disclosure under the Freedom of Information Act 2000. The confidentiality of this e-mail and your reply cannot be guaranteed, unless the information is legally exempt from disclosure.

Ref: Response to request  
Date: 10<sup>th</sup> October 2013

Mr G Basnett

**Information Governance  
Patient Services**  
Box number 153  
Addenbrooke's Hospital  
Cambridge Biomedical Campus  
Hills Road  
Cambridge CB2 0QQ

Switchboard: 01223 245151  
Direct Dial: 01223 348697

Email: [foi.contact@addenbrookes.nhs.uk](mailto:foi.contact@addenbrookes.nhs.uk)  
[www.cuh.org.uk](http://www.cuh.org.uk)

Dear Mr Basnett

Thank you for your request for information, received on 12<sup>th</sup> September 2013.

I can confirm that we hold the information that you have requested.

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

2. a) b) and c) The same for 2011/12

Please see the attached document

If you are unhappy with this decision then please do not hesitate to contact me. Your concerns or complaint will be fully investigated and a response sent to you within 20 working days, in exceptional circumstances this may take longer.

If you are still dissatisfied with how your request has been dealt with then you have the right to appeal to the Information Commissioner. The Information Commissioner is the supervisory body that has been put in place to oversee the Freedom of Information Act 2000. You can write to Information Commissioners Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Belinda Bruty  
Data Awareness Manager

## **Freedom of Information Request for Information – September 2013**

### **Introduction**

Services are provided to ensure the sensitive disposal or funeral arrangements for all fetal remains following pregnancy loss, or following death of a baby.

Losses occur to due miscarriage, intrauterine death, termination of pregnancy, stillbirth or neonatal death.

A funeral is required by law for all pregnancy losses or death of a baby that occurs during pregnancy or after birth at 24 or more weeks of gestation.

A funeral is not required by law when there has been fetal loss or death of a baby before 24 weeks (when the baby was born with no signs of life).

The unique significance and social meanings in relation to fetal remains is recognised. Provision is made for sensitive disposal procedures. Also provision is made to assist patients who wish to make specific funeral arrangements and this is available for patients with no distinction made with regard to gestation.

Provision is made for patients to have choice regarding sensitive disposal and funeral arrangements.

### **Sensitive Disposal**

Note that fetal remains or fetal tissue are never incinerated with clinical waste

No burial in groups takes place

Sensitive disposal takes place when patients request hospital based sensitive disposal. This provides for patients who wish for hospital arranged sensitive disposal with all cases identification anonymised, and also each arrangement may be individually audited.

In this way then under 13 weeks gestation provision is made for sensitive disposal of fetal remains by specific supervised incineration. Specific provision is always made for the sole incineration of fetal tissue, under supervision of Paediatric Pathology team and with the Hospital Lead Chaplain present.

In this way too sensitive disposal of fetal remains above 13 weeks gestation takes place when patients request hospital arranged sensitive disposal. Provision is made for sensitive disposal by cremation is made to take place in the Cambridge City Crematorium with the Lead Hospital Chaplain present. This is a group cremation.

### **Sensitive Disposal at the hospital site**

We are unable to provide data prior to February 2012  
Feb 2012- Dec 2012 = 462

Jan 2013-Sept 2013 = 335

### **Sensitive Disposal Service at the Crematorium**

July 2013-20

April 2013-20  
January 2013-11  
November 2012-20  
September 2012-10  
June 2012-20  
April 2012-20

### **Funeral Arrangements made following patient request**

Funeral arrangements are made by the Rosie Bereavement Support Team under the lead of the Specialist Bereavement Midwife

This service is available to any patient following pregnancy loss, or death of a baby at any gestation

### **Locations for cremation and burial:**

Parents have choices regarding location:

- Cambridge City Crematorium, Huntingdon Road, Cambridge
- Cambridge City Cemetery Newmarket Road
- Cambridge City Cemetery, Huntingdon Road
- Arbory Trust Woodland Burial Ground, Barton, Cambridge
- Other local cemeteries at parents request

### **Type of funeral**

Patients have choices regarding, type of funeral (cremation or burial) Patients have choice about whether to attend the funeral or not to attend the funeral in the Crematorium or cemetery.

Patients have choice regarding Chaplain, faith leader or secular officiant

### **2011**

Total of 152 funeral arrangements made on behalf of families

- 94 Cremation Arrangements made for Cambridge City Crematorium.
- 17 Burial Arrangements
- 41 families chose to make funeral arrangements with privately contracted funeral Services

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### **2012**

Total of 138 funeral arrangements made on behalf of families

- 81 Cremation Arrangements,
- 21 Burial Arrangements,
- 36 families chose to make funeral arrangements with privately contracted Funeral Services

**Freedom of Information Act Request – Reference Fol/14/032**  
**Disposal of Foetal Remains**

**Request details**

I am writing under the Freedom of Information to request records of disposal of all foetal remains from miscarriages, stillbirths and abortions where foetal matter was present from Cardiff and Vale University Hospital at both University Hospital of Wales (UHW) and University Hospital Llandough (UHL). More specifically: for 2012/13 and 2011/12

**Question 1**

How many foetuses / foetal remains from miscarriages, stillbirths and abortions were disposed of by the UHW and UHL (please only include situations where foetal matter was present)?

Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of foetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

**Response**

**a) Foetal Pathology Unit**

January 2011 – December 2011	45
January 2012 – December 2012	31
January 2013 – December 2013	40
Total	116

Cremation of 116 Foetal Remains at Thornhill Crematorium.

**b) Mortuary**

Information only available from October 2011

October – December	2011	136
January – December	2012	695
January – December	2013	871

All were disposed of via sensitive disposal. There is an All Wales Clinical Waste contract in place and within this contract all clinical waste is collected and transported off the UHB site to a location in Leeds.

We do not centrally record information as specifically as requested. To provide the level of detail requested would require a manual exercise accessing each individual record to identify the information requested. The UHB estimates this would exceed the time limit under the Act to provide a response and the UHB has therefore relied upon section 12 of the Act in respect of this element of your request. As has been stated previously when section 12 is being relied upon organisations are within their rights to refuse entire requests. We have however chosen to issue a response and provide such information as is routinely recorded and available in the spirit of openness and transparency.

In estimating whether complying with a request would exceed the appropriate limit, Regulation 4(3) states that an authority can only take into account the costs it reasonably expects to incur in:

- ^ determining whether it holds the information;
- ^ locating the information, or a document containing it;
- ^ retrieving the information, or a document containing it; and
- ^ extracting the information from a document containing it.

There are a total of 116 records that would need to be identified, retrieved and perused to provide the level of detail sought. It is considered that allowing approximately 15 minutes per record this would require a total of 29 hours of work being required to extract the requested information.  $116 \times 15$  minutes per record = 1740 minutes = 29 hours. Under the Act there is an allowance of two and a half days to comply with a request or 18 hours.

The cost limit set within the fees regulations is £450 for The UHB. The fees regulations specify that the cost of complying with a request must be calculated at the rate of £25 per hour. In this instance the cost of compliance would be £725.00

Dear Mr Basnett,

Thank you for your request under the Freedom of Information Act (FOI).

You requested:

1.a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)? 686

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are:

0 incinerated with clinical waste, 599 incinerated in groups, 0 incinerated individually, 41 cremated individually, 0 cremated in groups, 24 buried individually, 0 buried in groups, or 22 passed to families for their own arrangements.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites. Ipswich Hospital

2. a) b) and c) The same for 2011/12

2 a) In 2011/12, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)? 550

2. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are:

incinerated with clinical waste 0, incinerated in groups 502, incinerated individually 0, cremated individually 26, cremated in groups 0, buried individually 16, buried in groups 0, or passed to families for their own arrangements 16.

2. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites. Ipswich Hospital

Hopefully this answers your request.

If you are dissatisfied with the way Colchester Hospital University NHS Foundation Trust has handled your request for information, you can request a review by writing to :

*The Senior Information Risk Owner  
Colchester Hospital University NHS Foundation Trust  
Trust Headquarters  
Colchester General Hospital  
Turner Road  
Colchester, Essex, CO4 5JL*

*If you remain dissatisfied with the handling of your request or complaint, you have a right of appeal to the Information Commissioner at:*

*The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.*

*Telephone: 08456 30 60 60 or 01625 54 57 45 Website: [www.ico.gov.uk](http://www.ico.gov.uk)*

*There is no charge for making an appeal.*

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*If you have any ideas on how to improve our FOI service or changes that you'd like to see, then please submit a Feedback Form at [www.colchesterhospital.nhs.uk/foi\\_feedback.shtml](http://www.colchesterhospital.nhs.uk/foi_feedback.shtml). These can be completely anonymous and will help us to provide a better service in the future.*

*Kind Regards*

*The FOI Team at Colchester Hospital University NHS Foundation Trust*

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Colchester Hospital University NHS Foundation Trust, Turner Road, Essex, CO4 5JL

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[foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)  
 Response sent by email

St Helier Hospital  
 Wrythe Lane  
 Carshalton  
 Surrey SM5 1AA

Tel: 020 8296 2000  
 Direct Dial Tel: 020 8296 2406

11 October 2013

Dear Mr Basnett,

**Re: Freedom of Information request - Ref: FOI 1797**

Thank you for your recent request for information under the Freedom of Information (FOI) Act. Set out below is your original request followed by the Trust's response.

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

- Q1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?
- Q1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.
- Q1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.
- Q2. a) b) and c) The same for 2011/12

A1-A2.

Please see table and response below:

2012/2013	St Helier	Epsom
Hospital arranged funerals	53	
Hospital arranged cremations	52	23
Hospital arranged burials	1	23
Private funerals	16	0
Locations for hospital arranged	North East Surrey Crematorium	3
		Randalls Park Crematorium

funerals	Croydon Crematorium Sutton Cemetery	
Please note: All hospital cremations and burials are arranged individually		

2011/2012	St Helier	Epsom
Hospital arranged funerals	49	19
Hospital arranged cremations	48	19
Hospital arranged burials	1	0
Private funerals	16	11
Locations for hospital arranged funerals	North East Surrey Crematorium Randalls Park Crematorium Croydon Crematorium Sutton & Merton Joint Cemetery	Randalls Park Crematorium
Please note: All hospital cremations and burials are arranged individually		

We will always do what we can to ensure that, where possible, families can provide funerals, cremations or burials in these instances. However, there are occasions that we need to deal with products of conception (tissue that remains in the uterus after a miscarriage, planned pregnancy termination, or preterm/term delivery).

Products of conception specimens are dealt with in a sensitive and respectful manner at all times. Due to the nature of these specimens, they are processed in the normal way then kept separately from other routine specimens.

When the samples have been analysed, all the remaining products of conception tissue specimens are logged, placed into an individual container which is then placed in another container along with other products of conception specimens. This container is then sent for incineration.

At no time are specimens other than products of conception placed within this container.

If you have any queries about this letter, please contact the Freedom of Information office. Please remember to quote the reference number above in any future communications.

If you are unhappy with the way in which your Freedom of Information request has been handled and wish to raise any concerns, please contact Phil Ireland, Trust Secretary, at the address above or by email ([phil.ireland@esth.nhs.uk](mailto:phil.ireland@esth.nhs.uk)).

Should you still be dissatisfied with the outcome, you are entitled to contact the Information Commissioner at: Information Commissioner's Office (ICO), Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF.

Yours sincerely

Teresa O'Brien  
Freedom of Information Officer  
Communications and Corporate Affairs  
Epsom and St Helier University Hospitals NHS Trust  
Email: [foi@esth.nhs](mailto:foi@esth.nhs)  
Web: [www.epsom-sthelier.nhs.uk](http://www.epsom-sthelier.nhs.uk)

8 October 2013  
 Our reference: FOIRQ1752

Dear Mr Basnett

Please find below the information you requested under the Freedom of Information Act.

**Your request**

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

2. a) b) and c) The same for 2011/12

**Our response**

Please note that Great Ormond Street Hospital does not have maternity or gynaecology services. The information provided is from our Pathology and Cytogenetic services.

Pathology

Year	Question a)	Question b)	Question c)
2012/13	0	Not applicable	Not applicable
2011/12	4	All were placed in individual caskets and cremation was arranged via a funeral director.	Not applicable

Genetic laboratory

Notes for interpretation of data:

- Definition used to provide data: Foetal matter - where there is the presence of a whole foetus, or identifiable part of a foetus e.g. arm, leg, rib-cage. This does not include skin samples, chorionic villi, unidentifiable material, skin biopsies received from living patients, flasks of cultured cells and DNA samples – all of which are classed as ‘tissue’ samples by the laboratory.
- The Cytogenetics laboratory is a diagnostic laboratory and all foetuses/foetal material are either returned to the hospital of origin, or incinerated with clinical waste. The categories *incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements* are not applicable.
- The laboratory holds no information about the type of disposal procedures/events for those cases where the foetuses/foetal remains have been returned to the original hospital.

Year	Question a)	Question b)	Question c)
2012/13	29	13 were returned to the original hospital (at the request of that hospital). 12 were incinerated with clinical waste. 4 were used in their entirety to perform the genetic test requested.	G W Butler Rainham
2011/12	24	12 were returned to the original hospital (at the request of that hospital). 11 were incinerated with clinical waste. 1 was used in its entirety to perform the genetic test requested.	G W Butler Rainham

I trust that the information provided is sufficient and helps to answer any concerns, questions or issues you may have.

If you should have any further queries related to this request, please do not hesitate to contact me. Please ensure that the above reference number is quoted on any correspondence.

Yours sincerely

**Maria Björklund**  
 FOI Co-ordinator  
 Email foiteam@gosh.nhs.uk

[enclosed – Your rights – see next page]

**Your rights**

If you are not satisfied with the response to your request for information, please do not hesitate to contact the member of the FOI team whose name appears on the response letter. Please quote your reference number on any correspondence.

You can also write to the Assistant Head of Quality, Safety and Transformation – Risk Management at the following address:

Quality, Safety and Transformation team  
Great Ormond Street Hospital  
LONDON  
WC1N 3JH

If you are still not satisfied with your response, you also have the right to appeal to the Information Commissioner.

You can contact the Information Commissioner's Office at the following address:

Information Commissioner's Office  
Wycliffe House  
Water Lane  
Wilmslow  
Cheshire  
SK9 5AF

Freedom of Information Office  
Basingstoke and North Hampshire Hospital  
Aldermaston Road  
Basingstoke  
Hampshire  
RG24 9NA

Switchboard: 01256 473202  
E-mail: [foi@hhft.nhs.uk](mailto:foi@hhft.nhs.uk)

Date : 2<sup>nd</sup> October 2013  
Ref. No. : FOI 340/2013

By email : [foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Dear Mr Basnett,

**Your request for information under the Freedom of Information Act 2000**

I am writing further to your request for information regarding the disposal of foetal remains at the Trust. Your request for information is as follows and the information you require has been provided thereafter:

- 1 a) In 2012/13, how many foetuses/foetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital?
1. b) Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately, passed to families for their own arrangements.
1. c) For those incinerated or incinerated as clinical waste, please provide a list of locations where this was carried out.
2. a) b) and c) The same for 2011/12

**Information for questions 1a) and 2a)**

	2011	2012	2013 to date
Basingstoke and North Hampshire Hospital (BNHH)	63	62	36
Royal Hampshire County Hospital, Winchester (RHCH)	52	56	31

**Information for questions 1b) and 2b)**

	2011		2012		2013 to date	
	BNHH	RHCH	BNHH	RHCH	BNHH	RHCH
Incinerated with clinical waste	0	0	0	0	0	0
Incinerated in groups	8	0	2	0	0	0
Incinerated individually	0	0	0	0	1*	0
Cremated in groups	0	0	0	0	0	0
Cremated individually	21	37	25	41	10	27
Buried individually	0	0	0	0	0	0
Buried in groups	0	0	0	0	0	0
Passed to family for own arrangements	34	15	35	15	25	4

\*The Trust no longer uses the sensitive disposal option (incineration through SRCL) for any foetal remains. The trust ensures that all remains are now subject to individual cremation unless otherwise specified by the family. This incineration took place prior to the Trust wide agreement to stop the disposal of pre-24 week foetus' in this way.

**Information for 1c) and 2c)**

SRCL Frome  
Unit 4b Marshall Way  
Commerce Park  
Frome  
Somerset  
BA11 2SE

This letter confirms the completion of this request. A log of this request will be held on a database held by the Trust.

If you are unhappy about the response you have received your first line of action should be to write to request that the Trust undertake an internal review of your application. A senior member of staff, who was not involved with your initial application, will undertake this review. If after this process you are still not satisfied with the response you receive from the Trust you can complain to the Information Commissioner at the following address:

Information Commissioner, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF  
[www.ico.gov.uk](http://www.ico.gov.uk)

Yours sincerely,

Sharron Crowhurst  
Freedom of Information Office  
Hampshire Hospitals NHS Foundation Trust

Dear Guy

Thank you for your Freedom of Information request concerning disposal of fetal remains.

The Trust can provide the following information:

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriage, stillbirth and abortion.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital?

	Communal Cremations	Stillbirths /miscarriages	Abortion
2011/12	50	125	863
2012/13	60	146	728

1. b) Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately, passed to families for their own arrangements.

About the 24 week gestation or NVF [non-viable foetus]. Any remains below this mark can legally be disposed of by incineration or method of the hospital choice

For the very early gestations 8-17 weeks they would go on to a list for communal cremations this mean we would hold them in the mortuary until we have a complete list of 10 they are then sent for cremation at our contacted cemetery [city of London cemetery aldersbrook road E12 5DQ]

Most miscarriage are dealt with in this manner for the early gestations

Miscarriages for the 18weeks plus are normally classed as individual then the parents have the choice of burial or cremation

Stillbirth are normally over the 24 week gestations and would be for individual burial or cremation

Bereavement Midwives at our hospital care for families who have lost babies from 16 weeks gestation up until babies that die on the neonatal unit. This will include termination of pregnancy for medical reasons.

We offer all these families an Individual cremation or Burial. We do not group into gestation or type of loss for that reason we do not have separate figures for each type of baby loss (stilbirths/miscarriages)

Abortions are sent to the mortuary from theatre's for incineration. The company we use for disposal is sita.uk. they have lots of sites UK wide so I am unable to be more precise

(stats for surgical or late abortions at HUH - early medical procedures are done at home so HUH not involved in disposal of tissue).

1. c) For those incinerated or incinerated (with) clinical waste, please provide a list of locations where this was carried out- see above

2. a) b) and c) The same for 2011/12- see above

If you have any queries about this response please contact the information governance manager at [foi@homerton.nhs.uk](mailto:foi@homerton.nhs.uk), in the first instance. If, following that, you still have any concerns, you may contact the Information Commissioner either by letter, FOI/EIR Complaints resolution, Wycliffe House, Water Lane, Wilmslow, Cheshire SM9 5AF, or by email [www.informationcommissioner.gov.uk](http://www.informationcommissioner.gov.uk) to take them further.

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Yours sincerely

James Cook

Information Governance Administrator

Matthew Hall

Information Governance Manager (Deputy Caldicott Guardian)

Rothwell Road  
Kettering  
Northants  
NN16 8UZ

Main Switchboard: 01536 492000  
Direct Dial: 01536 491560  
Fax: 01536 493767  
e-mail: [lilos.bradley@kgh.nhs.uk](mailto:lilos.bradley@kgh.nhs.uk)  
Web: [www.kgh.nhs.uk](http://www.kgh.nhs.uk)

Our Ref: 1729

09 October 2013

[foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Dear Mr Basnett

*When calling, please ask for Llinos Bradley*

Thank you for your request for information dated 10 September 2013 which was received on 11 September 2013 requesting information about disposal of fetal remains.

In accordance with S.1(1)(a) of the Freedom of Information Act 2000 (FOIA), I can confirm that we do hold the information relevant to your request.

1. a) In 2012/13, how many fetuses/fetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital?

The Trust receives several hundred "retained products of conception" specimens per year, however very few of these contain identifiable fetal matter, and it is not possible to reasonably obtain data regarding the numbers that do contain fetal remains. We have therefore provided figures for all "products of conception" including those that did not contain fetal parts.

2012/13	Retained products of conception	= 342
	Fetuses	= 429

- b) Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately, passed to families for their own arrangements.

If fetal remains were identified during examination of tissue these would be cremated as a group and included in the figures below

2012/13	Products of conception incinerated with clinical waste	= 342
	Fetuses <20 weeks gestation – group cremation	= 384
	Fetuses >20 weeks gestation – individual cremation	= 45
	Fetuses/remains passed to families for disposal	= 27
	>24 weeks gestation = Normal arrangements apply	

Affiliated Teaching Hospital

- c) For those incinerated or incinerated as clinical waste, please provide the a list of locations where this was carried out.

All cremations by the hospital are carried out at Kettering Crematorium. Incineration as clinical waste is carried out according to the Trust's standard procedures.

The incineration of clinical waste is undertaken by contractors as part of a clinical waste management contract.

The Trust has undertaken a public interest test as to whether the information requested has the potential to affect public safety. The Trust believes that providing the locations where non-identifiable fetal material is sent for incineration could have the potential to undermine the security of those establishments that provide this service in that they could be targeted by certain campaign groups.

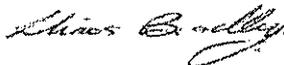
As a result of a public interest test the Trust is engaging an exception under regulation 12(5)(a) of the Environment Information Regulations 2004.

2. a) b) and c) The same for 2011/12

- |            |  |       |
|------------|--|-------|
| a) 2011/12 | Retained products of conception                        | = 357 |
|            | Fetuses  | = 461 |
| b) 2011/12 | Products of conception incinerated with clinical waste | = 357 |
|            | Fetuses <20 weeks gestation – group cremation          | = 422 |
|            | Fetuses >20 weeks gestation – individual cremation     | = 39  |
|            | Fetuses/remains passed to families for disposal        | = 23  |
|            | >24 weeks gestation = Normal arrangements apply        |       |

- c) Please see response to 1 (c) above

Yours sincerely



**Llinos Bradley**  
Freedom of Information Officer

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Disclaimer. This information should not be used to construct a database for direct marketing or unsolicited emails infringing the copyright in the material, or otherwise processed in contravention of the rights of the individual under the Data Protection Act.

If you are not satisfied with the Trust's response you may ask for an independent internal review by writing to the:-

Freedom of Information Officer  
Kettering General Hospital NHS Foundation Trust  
Rothwell Road  
Kettering  
Northants  
NN16 8UZ

If you remain dissatisfied after this internal review of the Trust's decision you may wish to make an approach to the Information Commissioner.

Information Commissioner  
Wycliffe House  
Water Lane  
Wilmslow  
Cheshire,  
SK95 5AF

<http://www.ico.gov.uk>

Please note that the Information Commissioner is a regulator, not an ombudsman. He will make an assessment as to whether or not the provisions of the Freedom of Information Act 2000 have been complied with. He can issue an enforcement notice to the Trust ordering it to comply with your request.

Mr Guy Basnett  
 foi.nhs@openworldnews.com

King's College Hospital  
 Denmark Hill  
 London SE5 9RS

30 October 2013

Tel: 020 3299 9000  
 Fax: 020 3299 3445  
 www.kch.nhs.uk

Dear Mr Basnett

**Re: Freedom of Information request - 1974**

Further to your request under the Freedom of Information Act 2000 (the Act) dated 12 September 2013, I am writing to confirm the information that the Trust does and does not hold.

The text of your request is repeated below in bold, followed by our response:

**REPLACEMENT REQUEST (September 12, 2013):**

**I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.**

**More specifically:**

Question	Answer
<b>1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?</b>	The Trust would have to review individual patient records to obtain this information and this would take longer than the permitted 18 hours under the FOI Act 2000. Therefore we are withholding this information under Section 12 of the Act.
<b>1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.</b>	Foetuses/fetal remains from early miscarriages and abortions are incinerated as clinical waste unless there is a parental request for burial/cremation. Still births would be cremated or buried depending on the parent's choice.
<b>1. c) For those incinerated individually, incinerated in groups, or incinerated as</b>	If the remains do go via the clinical waste route, the location of incineration would be:

clinical waste, please provide the a (sic) list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.	SRCL - Larkfield Unit 7, Larkfield Mill, Wellingham Way, Aylesford, ME20 68Q
2. a) b) and c) The same for 2011/12	See response to Question 1

I hope this fulfils your request. You can find out more about the Act and other information resources released by the Trust on our website at: [www.kch.nhs.uk](http://www.kch.nhs.uk)

If you are dissatisfied with the Trust's response, you may appeal to us in the first instance. For contact details and a copy of our FOI appeal process, please see our website or email us at [kch-tr.foi@nhs.net](mailto:kch-tr.foi@nhs.net)

If you remain dissatisfied, you have the right under section 50 of the Act to apply to the Information Commissioner to seek resolution to the matter. Further details can be found on their website at [www.ico.gov.uk](http://www.ico.gov.uk).

Yours sincerely,



**Fiona Nicholls**  
FOI Lead

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*The re-use of this information for any commercial purpose is subject to the Re-use of Public Sector Information Regulations 2005. Should you wish to re-use this information in any way you must ask us for specific permission relating to that you wish to use. If we agree to such re-use it may be subject to licensing and may involve a fee. Applications for re-use should be submitted to [sally.lingard@nhs.net](mailto:sally.lingard@nhs.net). No re-use should take place until you have formally asked for permission and we have informed you of our decision.*

10 October 2013

Mr Guy Basnett  
OpenWorld News

Foi.nhs@openworldnews.com

Kingston Hospital  
Chief Executive's  
Esher Wing, Level 4  
Galsworthy Road  
Kingston Upon Thames  
Surrey KT2 7QB

Janice.SorrellMcLeod@kingstonhospital.nhs.uk

Tel: 020 8934 2728  
Fax: 020 8934 2772

Dear Mr Basnett

**Re: Request under Freedom of Information Act 2000**

Thank you once again for your request under the Freedom of Information Act. For ease of reference I am including your original questions:

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)? In 2011-12 the trust arranged for 133 foetal remains to be buried in the children section of the Kingston cemetery. In 2012-13, 73 foetal remains have been similarly buried. The remains are buried in the presence of our lead chaplain or one of his deputies. Other products of conception are disposed of as part of the anatomical waste stream though we do not keep numbers disposed of

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

Foetal remains are buried in groups of 15-20; these are buried in the presence of our lead chaplain or one of his deputies. Please see under 1a;

Anatomical waste, regardless of type, is sealed, collected from wards/theatres and then incinerated by our clinical waste contractor.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

Please see under 1a above regarding foetal remains.

Regarding anatomical waste, in the interests of the health and safety of staff and of the general public the Trust will not release this information under section 38 of the Freedom of Information Act.

2. a) b) and c) The same for 2011/12

Please see above.

Please note that the information provided is the property of Kingston Hospital NHS Foundation Trust and subject to Intellectual Property and Database Rights. Any commercial application or use of this information *may* be subject to the provisions of the Re-use of Public Sector Information Regulations 2005. This means that if you wish to re-use the information provided for commercial purposes for any reason you must ask us for permission to do so. Should we agree that you can use the information it will be subject to the issue of a licence which may or may not involve a fee. If you have any questions about this process please contact me.

I hope the information provided meets your needs. If you are not satisfied with the Trust's response, the Trust does operate a Complaints Procedure for FOI requests. If you wish to complain about the way in which your request has been handled, then please write to the Chief Executive, Kate Grimes, at the address above. I enclose a copy of our Complaints Leaflet for your information. If you are then still not satisfied, you have the right under Section 50 of FOI to apply to the Information Commissioner (please see <http://www.ico.gov.uk>) for a decision on whether your application has been dealt with in accordance with the Act.

Yours sincerely



Mrs Janice Sorrell McLeod  
**Information Governance Manager**  
Freedom of Information Lead

Ref; 13-2144

Date: 25/09/2013

Open World News

EMAIL

Information Governance Team  
C/O Jagjivan Chagger  
Trust Headquarters  
St James's University Hospital  
Beckett Street  
Leeds  
LS9 7TF

Direct Line (0113) 2066821  
[informationgovernance@leedsth.nhs.uk](mailto:informationgovernance@leedsth.nhs.uk)

Dear Sir/Madam,

**Re: Freedom of Information request**

I am writing in response to your e-mail received on 12/09/2013 requesting information held by the Leeds Teaching Hospitals NHS Trust ("the Trust") under the provisions of the Freedom of Information Act 2000 ("the Act"). It is the responsibility of my team to respond to such requests on behalf of the Trust. Your queries are reproduced below along with our responses.

**1a.) In 2012/13, how many fetuses/foetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital?**

2012/2013 = 727

**1b.) Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately, passed to families for their own arrangements.**

This information is only partially recorded by the Trust and contains numbers for which fetuses/foetal remains were disposed of by Cremation or Burial, this has been incorporated within **Appendix A**.

**1c.) For those incinerated or incinerated as clinical waste, please provide a list of locations where this was carried out.**

In order to provide this we would need to undertake manual searches of individual Mortuary Records as these are not recorded within a readily available record. Due to the size of our organisation and the volume of information we would need to take into account, we reasonably consider that the time required to do this would exceed the appropriate cost limit of £450 as specified under section 12 of the Act and the associated Statutory Instrument 2004 No. 3244 "The Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulations 2004" ("the Fees Regulations"). The Trust is therefore not obliged to comply with your request in its current form.

**2a.) In 2011/12, how many fetuses/foetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital?**

2011/2012 = 871

**2b.) Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately, passed to families for their own arrangements.**

This information is only partially recorded by the Trust and contains numbers for which fetuses/foetal remains were disposed of by cremation or burial, this has been incorporated within **Appendix A**.

**2c.) For those incinerated or incinerated as clinical waste, please provide a list of locations where this was carried out.**

In order to provide this we would need to undertake manual searches of individual Mortuary Records as these are not recorded within a readily available record. Due to the size of our organisation and the volume of information we would need to take into account, we reasonably consider that the time required to do this would exceed the appropriate cost limit of £450 as specified under section 12 of the Act and the associated Statutory Instrument 2004 No. 3244 "The Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulations 2004" ("the Fees Regulations"). The Trust is therefore not obliged to comply with your request in its current form.

I would like to draw your attention to the provisions of the Re-use of Public Sector Information Regulations 2005. I should point out that the information we have supplied is the property of the Trust and subject to Intellectual Property and Database Rights. Any commercial application or use of this information may be subject to the provisions of the above Regulations. This means that if you wished to re-use any of the information provided for commercial purposes you would need to ask us for permission to do so. Should we agree that you can use the information it will be subject to the issue of a licence which may or may not involve a fee.

If for any reason you are unhappy with the service you have received in relation to your request, please contact the Information Governance team in the first instance using the details shown above.

If you continue to be dissatisfied, you have the right to contact the Information Commissioner. Generally, the Commissioner cannot make a decision until you have exhausted the Trust's complaints procedure. Should you wish to contact the Information Commissioner, you can do so by writing to The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF.

Yours sincerely

**Jagjivan Chagger**  
**Information Governance and Data Protection Manager**



PRIVATE AND CONFIDENTIAL

Our ref: MT/LF/1281  
Date: 16 October 2013

Email: [foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Crown Street  
Liverpool  
L8 7SS

Tel: 0151 708 9988  
[www.lwh.nhs.uk](http://www.lwh.nhs.uk)



Direct dial: 0151 702 4037  
Direct fax: 0151 708 6303  
Email: [foi@lwh.nhs.uk](mailto:foi@lwh.nhs.uk)

Dear Mr Basnett,

**Re: Freedom of Information – Request for Information**

I am writing in response to your request under the Freedom of Information Act on 10 September 2013. I apologise for the delay responding to you.

Please find enclosed response.

**1. a) In 2012/13, how many fetuses/fetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital?**

From April 2011 to March 2012, the Trust arranged disposal of fetal remains from miscarriages, still births and abortion 1,110 times

**In 2011/12**

From April 2012 to March 2013 the figure was 1,020

**1. b) Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately; passed to families for their own arrangements.**

Methods of disposal for April 2012 to March 2013 are:

Private Cremation – 20  
Private Burial – 31  
Hospital Cremation – 95  
Hospital Burial – 25  
Communal Cremations – 54  
Sensitive Disposal (includes incineration)- 795

Methods of disposal for April 2011 to March 2012 are:

Private Cremation - 17  
Private Burial - 26  
Hospital Cremation - 84  
Hospital Burial – 22  
Communal Cremations – 67  
Sensitive Disposal (includes incineration)- 894

**1. c) For those incinerated or incinerated as clinical waste, please provide the a list of locations where this was carried out.**

The location of disposal takes place in Salford and Manchester during 2011 – present day.

**2. a) b) and c) The same for 2011/12**

As above.

I hope this information meets the needs of the request. Should you require any further information please do not hesitate to contact me.

Yours faithfully

A handwritten signature in black ink that reads "Michelle Turner". The signature is written in a cursive, flowing style.

**Michelle Turner**  
**Director of Human Resources**

10<sup>th</sup> October 2013

Guy Basnett  
9 Heneage Street,  
Spitalfields,  
London  
E1 5LJ

Cliftonville  
Northampton  
NN1 5BD

Direct Dial: 01604 523881  
Switchboard: 01604 634700

E-mail- [foi@ngh.nhs.uk](mailto:foi@ngh.nhs.uk)

E-Mail: [foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Dear Mr Basnett

**Request under Freedom of Information Act 2000**

**Request Ref: NGFOI 13/14: 224**

**Response Letter**

Thank you for your request for information received at Northampton General Hospital NHS Trust (NGH) on 12<sup>th</sup> September.

I am pleased that we are now able to provide you with a response to your request as shown below.

---

You were requesting information regarding fetal remains.

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?
1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.
1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.
2. a) b) and c) The same for 2011/12



**Response from Northampton General Hospital NHS Trust (NGH):**

Data is held by calendar year and is listed below.

The number of fetal remains that were processed through the mortuary at NGH is as follows:

2011	- 125
2012	- 98
2013 to date	- 59

The method of disposal of the above remains is not recorded at NGH mortuary. These fetal remains are passed to funeral directors or family for arrangements to be made.

The number of fetal remains that were processed and incinerated through the Pathology department at NGH is as follows:

2011	- 323
2012	- 610
2013 to date	- 338

These fetal remains were incinerated individually offsite in accordance with relevant codes of practice.

---

We hope that you will find the information provided both informative and helpful. We also hope that you will be satisfied with the manner in which we have dealt with your Freedom of Information request. If not, please do let me know or you may ask for an independent internal review under the Freedom of Information complaints procedure at Northampton General Hospital NHS Trust. Internal review requests should be submitted within two months of the date of receipt of this response. Please see the attached leaflet.

If you remain dissatisfied after the internal review, you may make an approach to the Information Commissioner as outlined in the attached leaflet.

This completes the Trust response to your request, but please note:

The information provided is the property of Northampton General Hospital NHS Trust and subject to Copyright Protection, Intellectual Property and Database Rights. You are free to use the information supplied for your own use, including non-commercial research purposes. However, any other type of re-use including for example publishing the information or issuing copies to the public or any commercial application or use of this information may be subject to the provisions of the Re-use of Public Sector Information Regulations 2005. This means that if you wish to re-use the information provided for commercial purposes for any reason you must ask us for permission to do so. Should we agree that you can use the information it will be subject to the issue of a licence, which may or may not involve a fee.

If you have any questions about this process please contact:

Information Governance Manager  
Northampton General Hospital NHS Trust  
Cliftonville, Northampton  
NN1 5BD

Tel. (direct dial): 01604 523881

E-mail – [foi@ngh.nhs.uk](mailto:foi@ngh.nhs.uk)

If there is anything you need clarification on, please do not hesitate to contact me on the above address or if by e-mail to [foi@ngh.nhs.uk](mailto:foi@ngh.nhs.uk) quoting the reference NGFOI 13/14:224 in any future communications.

Yours sincerely,

*Sarah Checketts*

Information Governance Assistant  
Northampton General Hospital NHS Trust

Enc.



Dear Mr Basnett

Re: FOI/1999

Please find below the response to your request made under the Freedom of Information Act requesting information on the disposal of fetal remains.

If you are unhappy with the service you have received in relation to your request and wish to make a complaint or request a review of our decision, you should write to:

Megan Turmezei, Assistant Director, Special Projects, John Radcliffe Hospital, Headley Way, Headington, Oxford OX3 9DU.

Should you wish to make a complaint and are not happy with the outcome, you may apply directly to the Information Commissioner's Office (ICO) for a decision. Generally, the ICO cannot make a decision unless you have exhausted the internal complaints procedure. The ICO can be contacted at:

The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF

Provision of this information does not constitute permission for its commercial re-use in terms of the Re-Use of Public Sector Information Regulations 2005. You are free to use the information for your own use, including for non-commercial research purposes. The information may also be used for the purposes of news reporting. However, any other type of re-use will require permission from the Oxford University Hospitals NHS Trust.

Regards

Sarah Watkins

Planning and Information

John Radcliffe Hospital

Headley Way

Oxford

OX3 9DU

**From:** OpenWorld News [<mailto:foi.nhs@openworldnews.com>]

**Sent:** 12 September 2013 16:48

**To:** OpenWorld News

**Cc: Subject:** Re: FOI Request - Disposal of fetal remains

Dear Freedom of Information Officer,

I recently sent the FOI below on the disposal of fetal remains.

I have since received a few requests for clarification over some of the phrasing. I now wish to clarify that I am requesting only cases where fetal matter was present, and I've also clarified some of the examples of methods of disposal. I'd be grateful if you could disregard the previous FOI request (dated September 10, 2013), and accept this one in its place (dated September 12, 2013).

Please let me know if you have any questions.

**REPLACEMENT REQUEST (September 12, 2013):**

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

Deliveries before 12 weeks gestation:

**Jan - Dec 2011**

Under trust incineration policy	445
Returned to patient	14
Hospital burial	3

**Jan - Dec 2012**

Under Trust incineration policy	441
Returned to patient	8
Hospital burial	10

Deliveries between 12-24 weeks gestation receive a communal burial (Oxford) or cremation (Banbury) unless parents opt for their own private funeral which they fund.

2011 HGH)	95 (communal burials Oxford) 11 private funerals	30 (communal cremations
2012 HGH)	90 (communal burials Oxford) 13 private funerals	31 (communal cremations

All stillbirths receive a private funeral organised and funded by their parents.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

This information has not been disclosed here due to the negative consequences encountered as a result of the release of this type of information in the past.

2. a) b) and c) The same for 2011/12

See above.

If my request is denied in whole or in part, please justify all exemptions by reference to the Act.

Please let me know you have this email.

if there are any problems, or you need further information, please get in touch.

Many thanks,

Guy Basnett.

Plymouth Hospitals NHS Trust

Freedom of Information Act 2000 - Response

Our Ref: 13FOI270  
Your reference: Email dated 12/09/2013

[foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Dear Guy Basnett

**Subject:** Freedom of Information Act 2000  
**File Reference:** 13FOI270  
**Disclosure due date:** 10/10/2013  
**Disclosure date:** 06/01/2014

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I refer to your email dated 12/09/2013 in which you requested information under the terms of the Freedom of Information Act 2000. Plymouth Hospitals NHS Trust is confirming in accordance with section 1 (a) of the Act that it holds the information requested and is supplying it in accordance with section 1(b) unless otherwise specified by virtue of s41(1). Can I apologise for the lateness of our reply on this occasion. If you wish to take the matter further please refer to the satisfaction section of this reply letter.

**You asked and Plymouth Hospitals NHS Trust is supplying the following information.**

I recently sent the FOI below on the disposal of fetal remains.

I have since received a few requests for clarification over some of the phrasing. I now wish to clarify that I am requesting only cases where fetal matter was present, and I've also clarified some of the examples of methods of disposal. I'd be grateful if you could disregard the previous FOI request (dated September 10, 2013), and accept this one in its place (dated September 12, 2013). Please let me know if you have any questions.

**REPLACEMENT REQUEST (September 12, 2013):**

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

Numbers in 2012/13
70 stillbirth/non-viable fetuses
68 fetuses/fetal remains from miscarriages and clinical abortions
975 terminations

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

#### Bereavement Office

Babies: Non-viable fetuses and stillbirths for the year 2012/2013	
Buried individuals with parents in attendance	30
Cremated with parents in attendance	5 or less Exempt under Section 41(1) (a) and (b)
Cremation as per parent wishes	5 or less Exempt under Section 41(1) (a) and (b)
Passed to parents to arrange as they wished	36

#### Histopathology/Mortuary

All the fetuses disposed of by Histopathology/Mortuary department will have been buried in groups.

#### Sexual Health Services

Where surgical terminations have been carried out, the products of conception are collected individually in sealed containers and are incinerated in groups as sensitively as possible.

Where medical terminations have taken place, the fetuses are placed in a specimen pot (clear with yellow lid and no formalin). The specimen pots are

placed in a storage container within the designated ward area and disposed of as sensitively as possible by incineration.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

**Histopathology/Mortuary**

All the fetuses disposed of by Histopathology/Mortuary were sent for interment at Weston Mill Cemetery.

**Bereavement Office**

All individual funerals paid for by the Trust (burials/cremations) are at Weston Mill Cemetery, Plymouth.

**Sexual Health Services**

Terminations are disposed of as sensitively as possible by incineration. The hospital has its own incinerator.

2. a) In 2011/12, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

Numbers in 2011/12	
70 stillbirth/non-viable fetuses	
83 fetuses/fetal remains from miscarriages and clinical abortions	
1110 terminations	

2. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

**Bereavement Office**

Babies: Non-viable fetuses and stillbirths for the year 2011/2012	
Buried individuals with parents in attendance	23
Cremated with parents in attendance.	0
Cremation as per parent wishes	5 or less
	Exempt under Section 41(1) (a) and (b)

**Histopathology/Mortuary**

The Histopathology/Mortuary responses to 1b are the same as the answers above for that department.

**Sexual Health Services**

Terminations are disposed of as sensitively as possible by incineration. The hospital has its own incinerator.

**2. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.**

**Bereavement Office**

All individual funerals paid for by the trust (burials/cremations) are at Weston Mill Cemetery, Plymouth.

**Histopathology/Mortuary**

The Histopathology/Mortuary responses to 1b are the same as the answers above for that department.

**Sexual Health**

Terminations are disposed of as sensitively as possible by incineration. The hospital has its own incinerator.

**Rationale for the use of Section 41(1) (a) and (b) – Information provided in confidence**

The duty of care for a patient continues after death. Those deceased can expect the same level of confidentiality as expected by those living and the rules that govern it. The Trust is mindful that the obligation and on this occasion due to the sensitivity of the request figures of five or less have not been given as an exact figure. Plymouth Hospitals NHS Trust (PHNT) takes the view that it is not just the name, it can be a host of other details that when collated identify a person and link them to events. A jigsaw puzzle is a good example of how single pieces might not mean anything, but when the pieces are fitted together, a picture emerges. In the same way, the more information placed in the public domain the clearer the picture becomes. Normally this would be right and proper and provide the evidence that supports our accountability, however, where requested, information relates to individuals and events the Trust has a duty to ensure that it finds the right balance between the rights of the deceased, their family and the requirements of the Freedom of Information Act. This is particularly important when questions are very probing and an organisation has a duty of care. This is particularly important when considering our obligations under Article 8 of the European

Convention on Human Rights (the right to respect for private and family life, home and correspondence) and the risk of cause distress and damage to those affected by such a release. On balance, the Trust believes the Public is not served by the disclosure of low figures that form part of this request. We have provided section 16: Advice and assistance by providing a range to low figures.

**Attachments included: No**

If I can be of any further assistance to you please do not hesitate to contact me on ☎ 01752 431057.

**Satisfaction and appeal**

Would you kindly note that if you are unhappy with this response then you have the right to complain. This should be in writing to the Legal Department at Plymouth Hospitals NHS Trust or by email to [plh-tr.foi-requests@nhs.net](mailto:plh-tr.foi-requests@nhs.net) we will then arrange for an independent appeal.

Freedom of Information Manager  
Legal Department  
Plymouth Hospitals NHS Trust  
Central Records Library  
Bush Park  
Plymouth  
PL6 7RG

☎ 01752 431057

If you remain dissatisfied with the outcome of the appeal, then you have the right to appeal again to the Information Commissioner at:

Information Commissioner's Office  
Wycliffe House  
Water Lane  
Wilmslow  
Cheshire  
SK9 5AF

<http://www.ico.org.uk/complaints/getting>

Yours sincerely

Stuart Edmunds  
Freedom of Information Manager

Dear Mr Basnett,

Further to your request for information please find our response below.

regards,

Caroline Lynch  
Governance Officer  
Royal Berkshire NHS Foundation Trust

0118 322 5335

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**From:** OpenWorld News [mailto:foi.nhs@openworldnews.com]  
**Sent:** 12 September 2013 16:48  
**To:** OpenWorld News  
**Cc:** foi.manager@midstaffs.nhs.uk; foi@midyorks.nhs.uk; Foi.PublicationSchemeCo-ordinator@mkhospital.nhs.uk; foi@moorfields.nhs.uk; foi@nnuh.nhs.uk; helen.e.williamson@nbt.nhs.uk; foi.requests@ncuh.nhs.uk; freedomofinformation@nmh.nhs.uk; caroline.skipper@nth.nhs.uk; nwlh-tr.trust@nhs.net; foi@ngh.nhs.uk; david.lawrence@ndevon.swest.nhs.uk; nlg-tr.foi@nhs.net; foi@northumbria.nhs.uk; FOI@nuh.nhs.uk; foia@ouh.nhs.uk; corporate.affairs@papworth.nhs.uk; foi.trust@pat.nhs.uk; communications@pbh-tr.nhs.uk; plh-tr.foi-requests@nhs.net; InformationGovernancepht@poole.nhs.uk; foia.executive@porthosp.nhs.uk; FoI@qvh.nhs.uk; foi@rjah.nhs.uk; FOI; foi@rbht.nhs.uk; the.link@rcht.cornwall.nhs.uk; rde-tr.FOI@nhs.net; rfh.foi@nhs.net; foi@ribuht.nhs.uk; foi@rnhrd.nhs.uk; foi@rnoh.nhs.uk; rsc-tr.FreedomOfInformation@nhs.net; ruh-tr.FOIREquests@nhs.net; FOIrequest@srft.nhs.uk; freedomofinformation@salisbury.nhs.uk; swb-tr.SWBH-GM-FOI-Request@nhs.net; foi.requests@york.nhs.uk; sheffield.childrenshospital@sch.nhs.uk; foi@sth.nhs.uk; foi.requests@notts-his.nhs.uk; info@sath.nhs.uk; infogov.sdhct@nhs.net; slh-tr.foi@nhs.net; foi@stees.nhs.uk; FOI@stft.nhs.uk; i.g.acute@swh.nhs.uk; nicola.frost@southend.nhs.ukOther; soh-tr.foi@nhs.net; foi@stgeorges.nhs.uk; foirequests@sthk.nhs.uk  
**Subject:** Re: FOI Request - Disposal of fetal remains

Dear Freedom of Information Officer,

I recently sent the FOI below on the disposal of fetal remains.

I have since received a few requests for clarification over some of the phrasing. I now wish to clarify that I am requesting only cases where fetal matter was present, and I've also clarified some of the examples of methods of disposal. I'd be grateful if you could disregard the previous FOI request (dated September 10, 2013), and accept this one in its place (dated September 12, 2013).

Please let me know if you have any questions.

REPLACEMENT REQUEST (September 12, 2013):

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

388

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

\*Cremated or buried individually 65  
Cremated in groups 31  
Incinerated in groups 292

\* Not disposed of by the trust, but passed to undertakers for family funerals.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

Information not held by the trust. (Contractor carries out incineration off-site. Processes compliant with Human Tissue Act.)

2. a) b) and c) The same for 2011/12

(a) 611

(b) \*Cremated or buried individually 121,  
Cremated in groups 39,  
Incinerated in groups 451

(c) Information not held by the trust. (Contractor carries out incineration off-site. Processes compliant with Human Tissue Act.)

\* Not disposed of by the trust, but passed to undertakers for family funerals.

If my request is denied in whole or in part, please justify all exemptions by reference to the Act.

Please let me know you have this email.

if there are any problems, or you need further information, please get in touch.

Many thanks,

Guy Basnett.

Dear Mr Basnett

Further to your Freedom of Information request. The Trust has answered your questions in the order they appear in your request. Please see that your request has been coloured in blue and the Trust's response coloured in green.

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

Please see answer to question 1b

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are: incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

**Miscarriages 12/14 weeks and under - Monthly burial in groups:**

Products of conception from miscarriages are sent to the Histology Lab. The figures below include **all specimens of products of conception** sent to the Histology Lab when a miscarriage has occurred, as it is not possible to state how many of these cases contained foetal parts. All POC are buried in the same manner (irrespective of whether foetal parts were identified):

April 2011 to March 2012 = 241

April 2012 to March 2013 = 264

**Terminations 12/14 weeks and under - Sensitive disposal by incineration (incinerated as a group - separately from clinical waste):**

Please note these numbers are approximate, as figures for the number of remains incinerated are not collated separately. The information provided has been extracted from the Trust's coding system (all inpatient and daycase procedures are coded using national coding definitions). Absolute figures cannot be given due to the gestational age on some data not being available.

April 2011 to March 2012 = Approximately 800

April 2012 to March 2013 = Approximately 770

**Losses dealt with by the Bereavement Office including - 14 week gestations (occasionally from 12 weeks) up to full term. These include miscarriages, terminations, intra uterine deaths, stillbirths and neonatal deaths:**

Please note that the hospital provides an individual burial service for losses from 14 – 24 weeks gestation if it is required. No cremations are offered by the hospital. After 24 weeks the parents make their own arrangements.

April 2011 to March 2012:

Hospital Arranged Burials = 26

Private Burials = 30

Private Cremations = 17

Baby taken by parents to make private arrangements = 5

April 2012 to March 2013:

Hospital Arranged Burials = 37

Private Burials = 30

Private Cremations = 19

Baby taken by parents to make private arrangements = 6

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide a list of locations where this was carried out. I only want to know the location or locations where this happens, so there may only be one, or a few sites.

A facility in the South West. The facility is a fully licenced and registered plant where 'duty of care' visits are undertaken four times a year by a member of RD&E Trust staff.

2. a) b) and c) The same for 2011/12

See above

If you feel your enquiry has not been dealt with appropriately please refer any complaints to the Information Governance Manager, who will initiate an internal complaint procedure. Complainants who remain dissatisfied with the Trust at the end of the internal complaint procedure have the right to take their complaint to the Information Commissioner.

In order to enable us to make improvements in our service, I would be grateful if you could kindly take a few moments of your time to fill out the survey below. If you have any comments that you would like to make regarding the way your request was dealt with, please enter them in the comments section.

Please do not hesitate to contact me if I can be of further help.

Best Wishes

Charlotte

**Charlotte Pritchard**

**Senior Information Governance Analyst**

**Information Governance**

**Royal Devon and Exeter NHS Foundation Trust**

**Barrack Road**

**Exeter**

**Devon**

**EX2 5DW**

**New FOI email address: [rde-tr.FOI@nhs.net](mailto:rde-tr.FOI@nhs.net)**

\*\*\*\*\*

Dear Mr Basnett

Further to your request for information please see the responses below. We apologise for the delay in sending this information.

Your appeal rights

We hope that you will be satisfied with our response to your request, if not you may ask us to review our decision in which case you should write to Mr David Sloman, Chief Executive, Royal Free London NHS Foundation Trust, Pond Street, London NW3 2QG, explaining what you would like us to review and including your reference number. If you are not satisfied with the internal review, you can appeal to the Information Commissioner. The contact details are: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, telephone 01625 545 700 or see <http://www.ico.gov.uk/>

Yours sincerely

Jan Aps

Board Secretary

**From:** OpenWorld News [mailto:foi.nhs@openworldnews.com]  
**Sent:** 12 September 2013 16:48  
**To:** OpenWorld News  
**Cc:** foi.manager@midstaffs.nhs.uk; foi@midyorks.nhs.uk; Foi.PublicationSchemeCo-ordinator@mkhospital.nhs.uk; foi@moorfields.nhs.uk; foi@nnuh.nhs.uk; helen.e.williamson@nbt.nhs.uk; foi.requests@ncuh.nhs.uk; freedomofinformation@nmh.nhs.uk; caroline.skipper@nth.nhs.uk; Trust (NORTH WEST LONDON HOSPITALS NHS TRUST); foi@ngh.nhs.uk; david.lawrence@ndevon.swest.nhs.uk; foi (NORTHERN LINCOLNSHIRE AND GOOLE HOSPITALS NHS FOUNDATION TRUST); foi@northumbria.nhs.uk; FOI@nuh.nhs.uk; foi@ouh.nhs.uk; corporate.affairs@papworth.nhs.uk; foi.trust@pat.nhs.uk; communications@pbh-tr.nhs.uk; FOI-requests (PLYMOUTH HOSPITALS NHS TRUST - RK9); InformationGovernancepht@poole.nhs.uk; foia.executive@porthosp.nhs.uk; FoI@qvh.nhs.uk; requests foi (THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST); foi@royalberkshire.nhs.uk; foi@rbht.nhs.uk; the.link@rcht.cornwall.nhs.uk; FOI (ROYAL DEVON AND EXETER NHS FOUNDATION TRUST); foi rfh (ROYAL FREE LONDON NHS FOUNDATION TRUST); foi@rlbuht.nhs.uk; foi@rnhrd.nhs.uk; foi@rnoh.nhs.uk; FreedomOfInformation (ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST); FOIRequests (ROYAL UNITED HOSPITAL BATH NHS TRUST - RD1); FOIrequest@srft.nhs.uk; freedomofinformation@salisbury.nhs.uk; SWBH-GM-FOI-Request (SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST); foi.requests@york.nhs.uk; sheffield.childrenshospital@sch.nhs.uk; foi@sth.nhs.uk; foi.requests@notts-his.nhs.uk; info@sath.nhs.uk; sdhct infogov (SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST); foi (SOUTH LONDON HEALTHCARE NHS TRUST); foi@stees.nhs.uk; FOI@stft.nhs.uk; i.g.acute@swh.nhs.uk; nicola.frost@southend.nhs.uk; Other; FOI (SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST); foi@stgeorges.nhs.uk; foirequests@sthk.nhs.uk  
**Subject:** Re: FOI Request - Disposal of fetal remains

Dear Freedom of Information Officer,

I recently sent the FOI below on the disposal of fetal remains.

I have since received a few requests for clarification over some of the phrasing. I now wish to clarify that I am requesting only cases where fetal matter was present, and I've also clarified some of the examples of methods of disposal. I'd be grateful if you could disregard the previous FOI request (dated September 10, 2013), and accept this one in its place (dated September 12, 2013).

Please let me know if you have any questions.

**REPLACEMENT REQUEST (September 12, 2013):**

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

**Response**

FY 2012/3	FY 2011/12
342	349

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

**Response**

	FY 2012/3	FY 2011/12
<b>Communal cremations</b>	277	286
<b>Individual</b>	65	63
- <i>Individual burials</i>	42	41
- <i>Individual cremations</i>	23	22
<b>Incinerated as clinical waste</b>	Not recorded*	Not recorded*
<b>Total</b>	342	349

\* Data not recorded. Any specimens of foetal remains that require histopathology are sent to the histopathology department. Specimens requiring burial or additional testing are returned to the ward. Any other products of conception from evacuation of retained products of conception surgery or from termination of pregnancy are sent for incineration. We are unable to ascertain if the specimens have come from the wards or from theatres.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

**Insert response here**

Communal cremations were carried out at Golders Green crematorium.

All individual burials undertaken by the hospital are at St Pancras and Islington cemetery in the appropriate religious area. Jewish burials are normally undertaken by the burial societies and take place in their own burial areas.

All individual cremations undertaken by the hospital occur at Golders Green Crematorium.

Anatomical waste is disposed of via incineration by Veolia ES based in Birmingham.

2. a) b) and c) The same for 2011/12

**Response**

See 1 a, b and c above.

If my request is denied in whole or in part, please justify all exemptions by reference to the Act.

Please let me know you have this email.

if there are any problems, or you need further information, please get in touch.

Many thanks,

Guy Basnett.

15 October 2013  
[foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Ref: 370 2013

Information Governance  
Egerton Road  
Guildford  
Surrey  
GU2 7XX

Email: [rsc-tr.FreedomofInformation@nhs.net](mailto:rsc-tr.FreedomofInformation@nhs.net)  
Tel: 01483 571122

Dear Mr Basnett

**Request under Freedom of Information Act 2000**

Thank you once again for your request under the Freedom of Information Act. For ease of reference I am attaching your original questions:

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

**2012/2013**

Miscarriages : 246

Abortions : 340

Stillbirths : 0

**2011/2012**

Miscarriages : 231

Abortions : 314

Stillbirths : 0

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements. The Royal Surrey County Hospital NHS Foundation Trust (RSCH) does not collate a breakdown of such information as the methods of disposal vary as follows:

The RSCH Breast Surgery & Gynaecology ward, only admits patients requiring ERPC (evacuation of retained products of conception); this ward does not carry out any TOPs (termination of pregnancies / abortions).

RSCH Gynaecology theatres - ERPC samples are sent to Histology; TOP remains are treated as clinical waste.

RSCH A&E department - all early miscarriage fetal tissue sent to Histology.

RSCH Maternity Unit - all fetal remains from miscarriages and TOPs are placed in individual boxes and cremated in a group of up to a maximum of 4 babies a month.

If Histology identifies any fetal tissues/parts, these would be placed in individual, specifically designed boxes and cremated in a group.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites. Fetal tissue from TOPs are incinerated as clinical waste by an accredited firm, who would determine the location.

2. a) b) and c) The same for 2011/12 – Please see above.

Please note that the information provided is the property of the Royal Surrey County Hospital NHS Foundation Trust and subject to Intellectual Property Database rights. Any commercial application or use of this information *may* be subject to the provisions of the Re-use of Public Sector Information Regulations 2005. This means that if you wish to re-use the information provided for commercial purposes for any reason you must ask us for permission to do so.

This letter confirms the completion of this request. A log of this request will be held on a database held by the Trust.

I hope the information provided meets your needs. If you are dissatisfied with the Trust's response, you have the right to ask for an internal review. Internal review requests should be submitted within two months of the date of the response to your original request and should be sent to the Trust Company Secretary, at the address above.

If you are not content with the outcome of the internal review, you have the right under Section 50 of the FOI to apply directly to the Information Commissioner for a decision on whether your application has been dealt with in accordance with the Act. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely,



Ruth Drewett  
Freedom of Information Lead

Question 1:

Number of foetuses/foetal remains from miscarriages, stillbirths and abortions disposed of by the hospital

01/04/11 to 31/03/12	288
01/04/12 to 31/03/13	218

Question 2:

Breakdown by method of disposal

Disposal Method	01/04/11 to 31/03/12	01/04/12 to 31/03/13
Hospital Cremation	247	167
Hospital Burial - individual	11	12
Incineration	19	24
Return to family - individual	11	15

Hospital cremation is dependent on gestation:  
Up to 11 weeks +6 days individually wrapped and cremated in groups  
Above 12 weeks all cremated individually

Incineration is only offered up to 11 weeks + 6 days

Question 3:

Location where clinical waste is incinerated

SRCL Bournemouth  
Waste to Energy Facility  
Royal Bournemouth Hospital  
Bournemouth  
Dorset  
BH7 7DW

Question 4:

Information for 2011/12 - see above

Freedom of Information request

Response date: 20/11/2013

Our Ref: SD/FOI01264

Your request and the Trust's response

REPLACEMENT REQUEST (September 12, 2013):

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

2012/13 – non viable foetus that went to the Crematorium for cremation - 21

All of these are managed through our Bereavement Office with patient written consent and involvement if they want to.

Surgical cases - the products removed and then have histological examination.  
2012/13 Foetal parts identified in 5 cases

Disposal of all products of conception via incineration as separate "groups" and go to a contractor for licensed incineration disposal. All have a sensitive disposal sticker (tear drop sticker) on so clear sensitive sample.

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

From theatres, all products are labelled as sensitive waste for disposal (tear drop sticker), in a sealed box then it is collected by waste management in person, who put it in a yellow bin labelled "Healthcare Anatomical". All anatomical waste, including body parts, are sent together from this Trust for incineration.

Any products from the ward or histology lab following any required tests follow this same pathway. Numbers above (surgical cases).

All recognisable products or if patient requests that go to the crematorium, all go to the Mortuary. Again with tear drop sticker and correct paperwork go to the local Crematorium.

Any patient that wants to take their products home are given them in suitable container with health and safety instructions as the products will contain formalin or alcohol.

**1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.**

**2. a) b) and c) The same for 2011/12**

Torbay Crematorium, Torquay, Devon

South Warwickshire   
NHS Foundation Trust

Our ref: FOI 3828

8<sup>th</sup> October 2013

Information Governance  
Warwick Hospital  
Lakin Rd  
CV34 5BW

Tel: 01926 495321

Email: [i.g.acute@swft.nhs.uk](mailto:i.g.acute@swft.nhs.uk)

Dear Mr Basnett,

Re: Request for information under Freedom of Information Act 2000

Thank you for your request under the Freedom of Information Act 2000, which was received 10<sup>th</sup> September 2013.

You requested the following information:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital? 38 between 12 and 20 weeks. Please note information for under 12 weeks cannot be provided as we do not have a central repository which specifically records this.
1. b) Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately, passed to families for their own arrangements. All of the above are either buried or cremated individually. Under 12 weeks are respectfully incinerated.
1. c) For those incinerated or incinerated as clinical waste, please provide the a list of locations where this was carried out. N/A
2. a) b) and c) The same for 2011/12 .  
37 between 12 and 20 weeks. All of which are buried or cremated individually. Please note information for under 12 weeks cannot be provided as we do not have a central repository which specifically records this.

I trust that this information will be useful to you. Your Freedom of Information request has now been closed.

I also trust that you are satisfied with the way in which we have handled your request. If you are not you may contact our Information Governance Manager, SWFT, Lakin Road, Warwick, CV34 5BW. Alternatively you can write to the Information Commissioners Office, Wycliffe House, Water Lane, Cheshire, SK9 5AF

In order for us to improve our service we would be grateful if you would take the time to complete our online feedback form by [clicking here](#).

Yours sincerely,

Freedom of Information Team  
South Warwickshire NHS Foundation Trust

By e mail

foi.nhs@openworldnews.com

LRF/JP/LMS/FOI

1<sup>st</sup> October 2013

Mr P McNamara

Dear Mr McNamara

I refer to your request for information under the provisions of the Freedom of Information Act 2000.

You requested the following information:

**In 2012/13 and 2011/12, how many fetuses/fetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital?**

**Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately, passed to families for their own arrangements.**

**For those incinerated or incinerated as clinical waste, please provide a list of locations where this was carried out.**

2012/2013

1039 fetal remains were disposed of during the period  
408 incineration handled by Stericycle Inc  
529 monthly cremation service at the Royal Victoria Infirmary  
30 private cremation service

2011/2012

766 fetal remains were disposed of during the period  
301 incineration handled by Stericycle Inc  
439 monthly cremation service at the Royal Victoria Infirmary  
26 private cremation service

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Information you receive which is not subject to Crown Copyright continues to be protected by the copyright of the person, or organisation, from which the information originated. You must ensure that you gain their permission before reproducing any third party (non Crown Copyright) information.

If you have any queries about this letter, please contact Mrs Summers, Patient Relations Administrator, on 0191 2231382.

If you are unhappy with the service you have received in relation to your request and wish to make a complaint or request a review of our decision, you should write to The Patient Relations Manager, Patient Relations Department, The Newcastle upon Tyne Hospitals NHS Foundation Trust, The Freeman Hospital, Newcastle upon Tyne, NE7 7DN.

If you are not content with the outcome of your complaint, you may apply directly to the Information Commissioner for a decision. Generally, the ICO cannot make a decision unless you have exhausted the complaints procedure provided by the Patient Relations Department. The Information Commissioner can be contacted at: The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF.

Yours sincerely

Sir Leonard Fenwick CBE  
Chief Executive

Please reply to:  
Elizabeth Radahd  
FOI Co-ordinator  
Tel: 0161 291 3747  
Fax: 0161 291 4269  
Email: [foi@uhsm.nhs.uk](mailto:foi@uhsm.nhs.uk)

Wythenshawe Hospital  
Southmoor Road  
Wythenshawe  
Manchester  
M23 9LT

0161 998 7070

[www.uhsm.nhs.uk](http://www.uhsm.nhs.uk)

Our ref: FOI-13/270

10 October 2013

**Mr Guy Basnett**  
[foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Dear Mr Basnett

I am writing to confirm that the relevant departments have now completed their search for the information which you requested on 10 September 2013. The Trust is now able to provide you with the following information in relation to your request.

*I recently sent the FOI below on the disposal of fetal remains.*

*I have since received a few requests for clarification over some of the phrasing. I now wish to clarify that I am requesting only cases where fetal matter was present, and I've also clarified some of the examples of methods of disposal. I'd be grateful if you could disregard the previous FOI request (dated September 10, 2013), and accept this one in its place (dated September 12, 2013).*

*Please let me know if you have any questions.*

**REPLACEMENT REQUEST (September 12, 2013):**

*I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.*

*More specifically:*

*1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?*

**Please see table below.**

*1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.*

Please see table below.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

The incineration of clinical waste takes place at Hope Hospital.

2. a) b) and c) The same for 2011/12

	Abortio n: under 13 weeks	Miscarriage: under 16 weeks fetal matter sent to Histopathology	Abortion: 16 weeks for severe abnormalities (eg anencephaly	Miscarriage: Spontaneous losses 16 -24 weeks	Stillbirth: Over 24 weeks with no signs of life	Early Neonatal Losses: within 0 – 6 days
2011/12	185	37	16	24	19	4
2012/13	129	45	19	26	31	6
Incinerated with Clinical Waste	✓	Nil	Nil	Nil	Nil	Nil
Incinerated in Groups	Nil	✓	Nil	Nil	Nil	Nil
Incinerated Individually	Nil	Nil	Nil	Nil	Nil	Nil
Cremated Individually	Nil	Nil	Nil	Nil	Nil	Nil
Cremated in Groups	Nil	✓	✓	✓	Nil	Nil
Buried Individually	Nil	Nil	Nil	Nil	Nil	Nil
Buried in Groups	Nil	Nil	Nil	Nil	Nil	Nil
Parents Own Arrangements, Burial or Cremation <i>NB: If a baby is delivered with signs of life at any gestation ( even below 24 weeks) it is not included in a communal cremation service.</i>	Nil	There is no legal prohibition to parents requesting the return of the fetal remains	Parents own choice or via the hospital funeral undertaker. Burial or Cremation	Parents own choice or via the hospital funeral undertaker. Burial or Cremation	Parents own choice or via the hospital funeral undertaker. Burial or Cremation	Parents own choice or via the hospital funeral undertaker. Burial or Cremation

The Trust strives to offer sensitive care to bereaved families at the sad time of the loss of their baby. I will include in the response email to you some documentation which demonstrates the care that is taken by staff in dealing sensitively with grieving families which you may find helpful.



Please note that the Trust had a Service Level Agreement in place with another hospital within the timeframe requested but these figures have not been included.

The information supplied to you continues to be protected by the Copyright, Designs and Patents Act 1998. You are free to use it for your own purposes, including any non-commercial research you are doing and the purposes of news reporting. Any other reuse, for example commercial publication, would require the permission of the copyright holder.

Information you receive which is not subject to crown copyright continues to be protected by the copyright of the person, or organisation, from which the information originated. You must ensure that you gain their permission before reproducing any third party (non Crown Copyright) information.

If you are unhappy with the service you have received in relation to your request please do not hesitate to contact me and I will try to resolve the situation, alternatively should you wish to make a complaint you can write to:

Elizabeth Radahd  
FOI Co-ordinator  
Wythenshawe Hospital  
Southmoor Road  
M23 9LT

Or you can email your comments to [FOI@uhsm.nhs.uk](mailto:FOI@uhsm.nhs.uk)

If you do make a complaint and find you are not content with the outcome, you may apply directly to the Information Commissioner for a decision. Generally, the ICO cannot make a decision unless you have exhausted the complaints procedure. The Information Commissioner can be contacted at:

Information Commissioner's Office  
Wycliffe House  
Water Lane  
Wilmslow  
Cheshire  
SK9 5AF.

If you have any queries about this letter, please contact me on the details above.

Kind regards

Yours sincerely

**Mandy Bailey**  
Chief Nurse

University Hospitals **NHS**  
Coventry and Warwickshire

NHS Trust

University Hospital  
Clifford Bridge Road  
Coventry  
CV2 2DX

Direct Telephone: 024 7696 8813  
Direct Fax: 024 7696 8786  
E-mail address: Linda.nelson@uhcw.nhs.uk

Our ref: LAN/1661

**Mr Guy Basnett**  
By email only: [foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Dear Mr Basnett

We write further to your request for information under the Freedom of Information Act, and provide our response as detailed below.

**I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriage, stillbirth and abortion.**

**More specifically:**

**Q1.**

- a) In 2012/13, how many foetuses/fetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital?
- b) Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately, passed to families for their own arrangements.
- c) For those incinerated or incinerated as clinical waste, please provide a list of locations where this was carried out.  
The location used for incineration of clinical waste by the Trust is Redditch.

**Q2.**

- a) b) and c) The same for 2011/12

The answer to Q1 & Q2 a) & b) are given in the table below:

Method of disposal	2011/12	2012/13
Individual burial	26	12
Shared grave	29	16
Monthly burial	64	49
Cremation	24	16
TOTAL	143	93

Fetal remains under 12 weeks gestation are sent for incineration. The figures are given in the table below:

Year	Number
2011/12	45
2012/13	85

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Victoria Demery, Business Support Manager, UHCW, Clifford Bridge Road, Coventry CV2 2DX.

If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

**Linda Nelson**  
**Freedom of Information Officer**

Trust Headquarters

County Hospital

Union Walk

Hereford

HR1 2ER

Tel: 01432 364000  
Fax: 01432 365410

mail: [freedom.information@wvt.nhs.uk](mailto:freedom.information@wvt.nhs.uk)

8<sup>th</sup> January 2014

Dear Sir

**FREEDOM OF INFORMATION ACT 2000 – INFORMATION REQUEST 3530**

Your request for information has been considered and I am directed to inform you that Wye Valley will only be able to offer partial information for this request. We are unable to provide a breakdown on an individual basis or for the remains passed to families for their own arrangements.

Wye Valley NHS Trust is able to inform you that:

- 1<sup>st</sup> January 2011 – end December 2011 total of fetus/fetal remains – 628 incinerated by hospital
- 1<sup>st</sup> January 2012 – end December 2012 total of fetus/fetal remains – 664 incinerated by hospital
- 1<sup>st</sup> January 2013 – end August 2013 total of fetus/fetal remains – 360 incinerated by hospital

All fetus/fetal remains are blessed by the hospital chaplain, or other religious priest, at the parent's request.

This is then classified as anatomical waste and removed by SITA under licence to Alexander Hospital Incinerator, Redditch B98 7UB

We estimate that the cost of complying further with your request would exceed the appropriate limit of £450. The appropriate limit has been specified in the Freedom of Information and Data Protection (Appropriate Limit and Fees) regulations 2004 and for health services it is set at £450. This represents the estimated cost of one person spending 18 hours in determining whether the Trust holds the information, and locating, retrieving and extracting the information.

Under section 12 of the Freedom of Information Act the Trust is not obliged to comply with your request and we will not be progressing your request further.

If you have any queries or concerns contact details are given at the top of the letter.

If you are unhappy with the service you have received in relation to your requests and wish to make a complaint or request a review of our decision, you should write to:

Nicola Licence

Company Secretary

Wye Valley NHS Trust

Trust Headquarters

The County Hospital

Hereford

HR1 2ER

If you are not content with the outcome of your complaint, you may apply directly to the Information Commissioner for a decision and can be contacted at:

Information Commissioner's Office

Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF

Telephone: 01625 545 745

[www.ico.gov.uk](http://www.ico.gov.uk)

Yours faithfully

S. Clark

**FREEDOM OF INFORMATION CO-ORDINATOR**

Wye Valley NHS Trust

8 October 2013  
 Our reference: FOIRQ1752

Dear Mr Basnett

Please find below the information you requested under the Freedom of Information Act.

**Your request**

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

2. a) b) and c) The same for 2011/12

**Our response**

**Please note that Great Ormond Street Hospital does not have maternity or gynaecology services. The information provided is from our Pathology and Cytogenetic services.**

Pathology

Year	Question a)	Question b)	Question c)
2012/13	0	Not applicable	Not applicable
2011/12	4	All were placed in individual caskets and cremation was arranged via a funeral director.	Not applicable

Genetic laboratory

Notes for interpretation of data:

- Definition used to provide data: Foetal matter - where there is the presence of a whole foetus, or identifiable part of a foetus e.g. arm, leg, rib-cage. This does not include skin samples, chorionic villi, unidentifiable material, skin biopsies received from living patients, flasks of cultured cells and DNA samples – all of which are classed as 'tissue' samples by the laboratory.
- The Cytogenetics laboratory is a diagnostic laboratory and all fetuses/foetal material are either returned to the hospital of origin, or incinerated with clinical waste. The categories *incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements* are not applicable.
- The laboratory holds no information about the type of disposal procedures/events for those cases where the fetuses/foetal remains have been returned to the original hospital.

Year	Question a)	Question b)	Question c)
2012/13	29	13 were returned to the original hospital (at the request of that hospital). 12 were incinerated with clinical waste. 4 were used in their entirety to perform the genetic test requested.	G W Butler Rainham
2011/12	24	12 were returned to the original hospital (at the request of that hospital). 11 were incinerated with clinical waste. 1 was used in its entirety to perform the genetic test requested.	G W Butler Rainham

I trust that the information provided is sufficient and helps to answer any concerns, questions or issues you may have.

If you should have any further queries related to this request, please do not hesitate to contact me. Please ensure that the above reference number is quoted on any correspondence.

Yours sincerely

**Maria Björklund**  
**FOI Co-ordinator**  
 Email foiteam@gosh.nhs.uk

[enclosed – Your rights – see next page]

**Your rights**

If you are not satisfied with the response to your request for information, please do not hesitate to contact the member of the FOI team whose name appears on the response letter. Please quote your reference number on any correspondence.

You can also write to the Assistant Head of Quality, Safety and Transformation – Risk Management at the following address:

Quality, Safety and Transformation team  
Great Ormond Street Hospital  
LONDON  
WC1N 3JH

If you are still not satisfied with your response, you also have the right to appeal to the Information Commissioner.

You can contact the Information Commissioner's Office at the following address:

Information Commissioner's Office  
Wycliffe House  
Water Lane  
Wilmslow  
Cheshire  
SK9 5AF

Our Ref: 1729

*When calling, please ask for Llinos Bradley*

09 October 2013

[foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Dear Mr Basnett

Thank you for your request for information dated 10 September 2013 which was received on 11 September 2013 requesting information about disposal of fetal remains.

In accordance with S.1(1)(a) of the Freedom of Information Act 2000 (FOIA), I can confirm that we do hold the information relevant to your request.

1. a) In 2012/13, how many fetuses/fetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital?

The Trust receives several hundred "retained products of conception" specimens per year, however very few of these contain identifiable fetal matter, and it is not possible to reasonably obtain data regarding the numbers that do contain fetal remains. We have therefore provided figures for all "products of conception" including those that did not contain fetal parts.

2012/13	Retained products of conception	= 342
	Fetuses	= 429

- b) Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately, passed to families for their own arrangements.

If fetal remains were identified during examination of tissue these would be cremated as a group and included in the figures below

2012/13	Products of conception incinerated with clinical waste	= 342
	Fetuses <20 weeks gestation – group cremation	= 384
	Fetuses >20 weeks gestation – individual cremation	= 45
	Fetuses/remains passed to families for disposal	= 27
	>24 weeks gestation = Normal arrangements apply	

- c) For those incinerated or incinerated as clinical waste, please provide the a list of locations where this was carried out.

All cremations by the hospital are carried out at Kettering Crematorium. Incineration as clinical waste is carried out according to the Trust's standard procedures.

The incineration of clinical waste is undertaken by contractors as part of a clinical waste management contract.

The Trust has undertaken a public interest test as to whether the information requested has the potential to affect public safety. The Trust believes that providing the locations where non-identifiable fetal material is sent for incineration could have the potential to undermine the security of those establishments that provide this service in that they could be targeted by certain campaign groups.

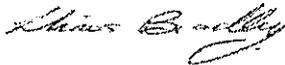
As a result of a public interest test the Trust is engaging an exception under regulation 12(5)(a) of the Environment Information Regulations 2004.

2. a) b) and c) The same for 2011/12

a) 2011/12	Retained products of conception	= 357
	Fetuses	= 461
b) 2011/12	Products of conception incinerated with clinical waste	= 357
	Fetuses <20 weeks gestation – group cremation	= 422
	Fetuses >20 weeks gestation – individual cremation	= 39
	Fetuses/remains passed to families for disposal	= 23
	>24 weeks gestation = Normal arrangements apply	

- c) Please see response to 1 (c) above

Yours sincerely



**Llinos Bradley**  
Freedom of Information Officer

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Affiliated Teaching Hospital

If you are not satisfied with the Trust's response you may ask for an independent internal review by writing to the:-

Freedom of Information Officer  
Kettering General Hospital NHS Foundation Trust  
Rothwell Road  
Kettering  
Northants  
NN16 8UZ

If you remain dissatisfied after this internal review of the Trust's decision you may wish to make an approach to the Information Commissioner.

Information Commissioner  
Wycliffe House  
Water Lane  
Wilmslow  
Cheshire,  
SK95 5AF

<http://www.ico.gov.uk>

Please note that the Information Commissioner is a regulator, not an ombudsman. He will make an assessment as to whether or not the provisions of the Freedom of Information Act 2000 have been complied with. He can issue an enforcement notice to the Trust ordering it to comply with your request.



Chairman: Graham Foster JP  
Interim Chief Executive: Fiona Wise

Mr Guy Basnett  
foi.nhs@openworldnews.com

King's College Hospital  
Denmark Hill  
London SE5 9RS

30 October 2013

Tel: 020 3299 9000  
Fax: 020 3299 3445  
www.kch.nhs.uk

Dear Mr Basnett

**Re: Freedom of Information request - 1974**

Further to your request under the Freedom of Information Act 2000 (the Act) dated 12 September 2013, I am writing to confirm the information that the Trust does and does not hold.

The text of your request is repeated below in bold, followed by our response:

**REPLACEMENT REQUEST (September 12, 2013):**

**I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.**

**More specifically:**

<b>Question</b>	<b>Answer</b>
<b>1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?</b>	The Trust would have to review individual patient records to obtain this information and this would take longer than the permitted 18 hours under the FOI Act 2000. Therefore we are withholding this information under Section 12 of the Act.
<b>1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.</b>	Foetuses/fetal remains from early miscarriages and abortions are incinerated as clinical waste unless there is a parental request for burial/cremation. Still births would be cremated or buried depending on the parent's choice.
<b>1. c) For those incinerated individually, incinerated in groups, or incinerated as</b>	If the remains do go via the clinical waste route, the location of incineration would be:

clinical waste, please provide the a (sic) list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.	SRCL - Larkfield Unit 7, Larkfield Mill, Wellingham Way, Aylesford, ME20 68Q
2. a) b) and c) The same for 2011/12	See response to Question 1

I hope this fulfils your request. You can find out more about the Act and other information resources released by the Trust on our website at: [www.kch.nhs.uk](http://www.kch.nhs.uk)

If you are dissatisfied with the Trust's response, you may appeal to us in the first instance. For contact details and a copy of our FOI appeal process, please see our website or email us at [kch-tr.foi@nhs.net](mailto:kch-tr.foi@nhs.net)

If you remain dissatisfied, you have the right under section 50 of the Act to apply to the Information Commissioner to seek resolution to the matter. Further details can be found on their website at [www.ico.gov.uk](http://www.ico.gov.uk).

Yours sincerely,



**Fiona Nicholls**  
FOI Lead

*The copyright to the information we are disclosing is held by King's College Hospital NHS Foundation Trust. The Trust and any other party who may own information included in these materials are entitled to protect their copyright.*

*The re-use of this information for any commercial purpose is subject to the Re-use of Public Sector Information Regulations 2005. Should you wish to re-use this information in any way you must ask us for specific permission relating to that you wish to use. If we agree to such re-use it may be subject to licensing and may involve a fee. Applications for re-use should be submitted to [sally.lingard@nhs.net](mailto:sally.lingard@nhs.net). No re-use should take place until you have formally asked for permission and we have informed you of our decision.*

10 October 2013

Kingston Hospital   
NHS Foundation Trust

Mr Guy Basnett  
OpenWorld News

Foi.nhs@openworldnews.com

Kingston Hospital  
Chief Executive's  
Esher Wing, Level 4  
Galsworthy Road  
Kingston Upon Thames  
Surrey KT2 7QB

Janice.SorrellMcLeod@kingstonhospital.nhs.uk

Tel: 020 8934 2728  
Fax: 020 8934 2772

Dear Mr Basnett

**Re: Request under Freedom of Information Act 2000**

Thank you once again for your request under the Freedom of Information Act. For ease of reference I am including your original questions:

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)? In 2011-12 the trust arranged for 133 foetal remains to be buried in the children section of the Kingston cemetery. In 2012-13, 73 foetal remains have been similarly buried. The remains are buried in the presence of our lead chaplain or one of his deputies. Other products of conception are disposed of as part of the anatomical waste stream though we do not keep numbers disposed of

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

Foetal remains are buried in groups of 15-20; these are buried in the presence of our lead chaplain or one of his deputies. Please see under 1a;

Anatomical waste, regardless of type, is sealed, collected from wards/theatres and then incinerated by our clinical waste contractor.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

Please see under 1a above regarding foetal remains.

Regarding anatomical waste, in the interests of the health and safety of staff and of the general public the Trust will not release this information under section 38 of the Freedom of Information Act.

2. a) b) and c) The same for 2011/12

Please see above.

Please note that the information provided is the property of Kingston Hospital NHS Foundation Trust and subject to Intellectual Property and Database Rights. Any commercial application or use of this information *may* be subject to the provisions of the Re-use of Public Sector Information Regulations 2005. This means that if you wish to re-use the information provided for commercial purposes for any reason you must ask us for permission to do so. Should we agree that you can use the information it will be subject to the issue of a licence which may or may not involve a fee. If you have any questions about this process please contact me.

I hope the information provided meets your needs. If you are not satisfied with the Trust's response, the Trust does operate a Complaints Procedure for FOI requests. If you wish to complain about the way in which your request has been handled, then please write to the Chief Executive, Kate Grimes, at the address above. I enclose a copy of our Complaints Leaflet for your information. If you are then still not satisfied, you have the right under Section 50 of FOI to apply to the Information Commissioner (please see <http://www.ico.gov.uk>) for a decision on whether your application has been dealt with in accordance with the Act.

Yours sincerely



Mrs Janice Sorrell McLeod  
**Information Governance Manager**  
Freedom of Information Lead

Dear Mr Basnett .

Further to your request for information please see the responses below. We apologise for the delay in sending this information.

Your appeal rights

We hope that you will be satisfied with our response to your request, if not you may ask us to review our decision in which case you should write to Mr David Sloman, Chief Executive, Royal Free London NHS Foundation Trust, Pond Street, London NW3 2QG, explaining what you would like us to review and including your reference number. If you are not satisfied with the internal review, you can appeal to the Information Commissioner. The contact details are: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, telephone 01625 545 700 or see <http://www.ico.gov.uk/>

Yours sincerely

Jan Aps

Board Secretary

**From:** OpenWorld News [mailto:foi.nhs@openworldnews.com]

**Sent:** 12 September 2013 16:48

**To:** OpenWorld News

**Cc:** foi.manager@midstaffs.nhs.uk; foi@midyorks.nhs.uk; Foi.PublicationSchemeCo-ordinator@mkhospital.nhs.uk; foi@moorfields.nhs.uk; foi@nnuh.nhs.uk; helen.e.williamson@nbt.nhs.uk; foi.requests@ncuh.nhs.uk; freedomofinformation@nmh.nhs.uk; caroline.skipper@nth.nhs.uk; Trust (NORTH WEST LONDON HOSPITALS NHS TRUST); foi@ngh.nhs.uk; david.lawrence@ndevon.swest.nhs.uk; foi (NORTHERN LINCOLNSHIRE AND GOOLE HOSPITALS NHS FOUNDATION TRUST); foi@northumbria.nhs.uk; FOI@nuh.nhs.uk; foia@ouh.nhs.uk; corporate.affairs@papworth.nhs.uk; foi.trust@pat.nhs.uk; communications@pbh-tr.nhs.uk; FOI-requests (PLYMOUTH HOSPITALS NHS TRUST - RK9); InformationGovernancepht@poole.nhs.uk; foia.executive@porthosp.nhs.uk; FoI@qvh.nhs.uk; requests foi (THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST); foi@royalberkshire.nhs.uk; foi@rbht.nhs.uk; the.link@rcht.cornwall.nhs.uk; FOI (ROYAL DEVON AND EXETER NHS FOUNDATION TRUST); foi rfh (ROYAL FREE LONDON NHS FOUNDATION TRUST); foi@rlbuht.nhs.uk; foi@rnhrd.nhs.uk; foi@rnoh.nhs.uk; FreedomOfInformation (ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST); FOIRequests (ROYAL UNITED HOSPITAL BATH NHS TRUST - RD1); FOIrequest@srft.nhs.uk; freedomofinformation@salisbury.nhs.uk; SWBH-GM-FOI-Request (SANDWELL AND WEST-BIRMINGHAM HOSPITALS NHS TRUST); foi.requests@york.nhs.uk; sheffield.childrenshospital@sch.nhs.uk; foi@sth.nhs.uk; foi.requests@notts-his.nhs.uk; info@sath.nhs.uk; sdhct infogov (SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST); foi (SOUTH LONDON HEALTHCARE NHS TRUST); foi@stees.nhs.uk; FOI@stft.nhs.uk; i.g.acute@swh.nhs.uk; nicola.frost@southend.nhs.uk; FOI (SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST); foi@stgeorges.nhs.uk; foirequests@sthk.nhs.uk

**Subject:** Re: FOI Request - Disposal of fetal remains

Dear Freedom of Information Officer,

I recently sent the FOI below on the disposal of fetal remains.

I have since received a few requests for clarification over some of the phrasing. I now wish to clarify that I am requesting only cases where fetal matter was present, and I've also clarified some of the examples of methods of disposal. I'd be grateful if you could disregard the previous FOI request (dated September 10, 2013), and accept this one in its place (dated September 12, 2013).

Please let me know if you have any questions.

REPLACEMENT REQUEST (September 12, 2013):

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

Response

FY 2012/3	FY 2011/12
342	349

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

Response

	FY 2012/3	FY 2011/12
<b>Communal cremations</b>	277	286
<b>Individual</b>	65	63
-Individual burials	42	41
- Individual cremations	23	22
<b>Incinerated as clinical waste</b>	Not recorded*	Not recorded*
<b>Total</b>	342	349

\* Data not recorded. Any specimens of foetal remains that require histopathology are sent to the histopathology department. Specimens requiring burial or additional testing are returned to the ward. Any other products of conception from evacuation of retained products of conception surgery or from termination of pregnancy are sent for incineration. We are unable to ascertain if the specimens have come from the wards or from theatres.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

**Insert response here**

Communal cremations were carried out at Golders Green crematorium.

All individual burials undertaken by the hospital are at St Pancras and Islington cemetery in the appropriate religious area. Jewish burials are normally undertaken by the burial societies and take place in their own burial areas.

All individual cremations undertaken by the hospital occur at Golders Green Crematorium.

Anatomical waste is disposed of via incineration by Veolia ES based in Birmingham.

2. a) b) and c) The same for 2011/12

**Response**

See 1 a, b and c above.

If my request is denied in whole or in part, please justify all exemptions by reference to the Act.

Please let me know you have this email.

if there are any problems, or you need further information, please get in touch.

---

Many thanks,

Guy Basnett.

15 October 2013

[foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Ref: 370 2013

**Information Governance**

Egerton Road

Guildford

Surrey

GU2 7XX

Email: [rsc-tr.FreedomofInformation@nhs.net](mailto:rsc-tr.FreedomofInformation@nhs.net)

Tel: 01483 571122

Dear Mr Basnett

**Request under Freedom of Information Act 2000**

Thank you once again for your request under the Freedom of Information Act. For ease of reference I am attaching your original questions:

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

**More specifically:**

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

**2012/2013**

Miscarriages : 246

Abortions : 340

Stillbirths : 0

**2011/2012**

Miscarriages : 231

Abortions : 314

Stillbirths : 0

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

The Royal Surrey County Hospital NHS Foundation Trust (RSCH) does not collate a breakdown of such information as the methods of disposal vary as follows:

The RSCH Breast Surgery & Gynaecology ward, only admits patients requiring ERPC (evacuation of retained products of conception); this ward does not carry out any TOPs (termination of pregnancies / abortions).

RSCH Gynaecology theatres - ERPC samples are sent to Histology; TOP remains are treated as clinical waste.

RSCH A&E department - all early miscarriage fetal tissue sent to Histology.

RSCH Maternity Unit - all fetal remains from miscarriages and TOPs are placed in individual boxes and cremated in a group of up to a maximum of 4 babies a month.

If Histology identifies any fetal tissues/parts, these would be placed in individual, specifically designed boxes and cremated in a group.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites. Fetal tissue from TOPs are incinerated as clinical waste by an accredited firm, who would determine the location.

2. a) b) and c) The same for 2011/12 – Please see above.

Please note that the information provided is the property of the Royal Surrey County Hospital NHS Foundation Trust and subject to Intellectual Property Database rights. Any commercial application or use of this information *may* be subject to the provisions of the Re-use of Public Sector Information Regulations 2005. This means that if you wish to re-use the information provided for commercial purposes for any reason you must ask us for permission to do so.

This letter confirms the completion of this request. A log of this request will be held on a database held by the Trust.

I hope the information provided meets your needs. If you are dissatisfied with the Trust's response, you have the right to ask for an internal review. Internal review requests should be submitted within two months of the date of the response to your original request and should be sent to the Trust Company Secretary, at the address above.

If you are not content with the outcome of the internal review, you have the right under Section 50 of the FOI to apply directly to the Information Commissioner for a decision on whether your application has been dealt with in accordance with the Act. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely,



Ruth Drewett  
Freedom of Information Lead

Question 1:

Number of fetuses/foetal remains from miscarriages, stillbirths and abortions disposed of by the hospital

01/04/11 to 31/03/12	288
01/04/12 to 31/03/13	218

Question 2:

Breakdown by method of disposal

Disposal Method	01/04/11 to 31/03/12	01/04/12 to 31/03/13
Hospital Cremation	247	167
Hospital Burial - individual	11	12
Incineration	19	24
Return to family - individual	11	15

Hospital cremation is dependent on gestation:  
Up to 11 weeks +6 days individually wrapped and cremated in groups  
Above 12 weeks all cremated individually

Incineration is only offered up to 11 weeks + 6 days

Question 3:

Location where clinical waste is incinerated

SRCL Bournemouth  
Waste to Energy Facility  
Royal Bournemouth Hospital  
Bournemouth  
Dorset  
BH7 7DW

Question 4:

Information for 2011/12 - see above

By e mail

foi.nhs@openworldnews.com

LRF/JP/LMS/FOI

1<sup>st</sup> October 2013

Mr P McNamara

Dear Mr McNamara

I refer to your request for information under the provisions of the Freedom of Information Act 2000.

You requested the following information:

**In 2012/13 and 2011/12, how many fetuses/fetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital?**

**Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately, passed to families for their own arrangements.**

**For those incinerated or incinerated as clinical waste, please provide a list of locations where this was carried out.**

2012/2013

1039 fetal remains were disposed of during the period  
408 incineration handled by Stericycle Inc  
529 monthly cremation service at the Royal Victoria Infirmary  
30 private cremation service

2011/2012

766 fetal remains were disposed of during the period  
301 incineration handled by Stericycle Inc  
439 monthly cremation service at the Royal Victoria Infirmary  
26 private cremation service

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Information you receive which is not subject to Crown Copyright continues to be protected by the copyright of the person, or organisation, from which the information originated. You must ensure that you gain their permission before reproducing any third party (non Crown Copyright) information.

If you have any queries about this letter, please contact Mrs Summers, Patient Relations Administrator, on 0191 2231382.

If you are unhappy with the service you have received in relation to your request and wish to make a complaint or request a review of our decision, you should write to The Patient Relations Manager, Patient Relations Department, The Newcastle upon Tyne Hospitals NHS Foundation Trust, The Freeman Hospital, Newcastle upon Tyne, NE7 7DN.

If you are not content with the outcome of your complaint, you may apply directly to the Information Commissioner for a decision. Generally, the ICO cannot make a decision unless you have exhausted the complaints procedure provided by the Patient Relations Department. The Information Commissioner can be contacted at: The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF.

Yours sincerely

Sir Leonard Fenwick CBE  
Chief Executive

---

Please reply to:  
Elizabeth Radahd  
FOI Co-ordinator  
Tel: 0161 291 3747  
Fax: 0161 291 4269  
Email: [foi@uhsm.nhs.uk](mailto:foi@uhsm.nhs.uk)

Wythenshawe Hospital  
Southmoor Road  
Wythenshawe  
Manchester  
M23 9LT

0161 998 7070

[www.uhsm.nhs.uk](http://www.uhsm.nhs.uk)

Our ref: FOI-13/270.

10 October 2013

**Mr Guy Basnett**  
[foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Dear Mr Basnett

I am writing to confirm that the relevant departments have now completed their search for the information which you requested on 10 September 2013. The Trust is now able to provide you with the following information in relation to your request.

*I recently sent the FOI below on the disposal of fetal remains.*

*I have since received a few requests for clarification over some of the phrasing. I now wish to clarify that I am requesting only cases where fetal matter was present, and I've also clarified some of the examples of methods of disposal. I'd be grateful if you could disregard the previous FOI request (dated September 10, 2013), and accept this one in its place (dated September 12, 2013).*

*Please let me know if you have any questions.*

**REPLACEMENT REQUEST (September 12, 2013):**

*I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.*

*More specifically:*

*1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?*

**Please see table below.**

*1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.*

Please see table below.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

The incineration of clinical waste takes place at Hope Hospital.

2. a) b) and c) The same for 2011/12

	Abortion: under 13 weeks	Miscarriage: under 16 weeks fetal matter sent to Histopathology	Abortion: 16 weeks for severe abnormalities (eg anencephaly)	Miscarriage: Spontaneous losses 16-24 weeks	Stillbirth: Over 24 weeks with no signs of life	Early Neonatal Losses: within 0-6 days
2011/12	185	37	16	24	19	4
2012/13	129	45	19	26	31	6
Incinerated with Clinical Waste	✓	Nil	Nil	Nil	Nil	Nil
Incinerated in Groups	Nil	✓	Nil	Nil	Nil	Nil
Incinerated Individually	Nil	Nil	Nil	Nil	Nil	Nil
Cremated Individually	Nil	Nil	Nil	Nil	Nil	Nil
Cremated in Groups	Nil	✓	✓	✓	Nil	Nil
Buried Individually	Nil	Nil	Nil	Nil	Nil	Nil
Buried in Groups	Nil	Nil	Nil	Nil	Nil	Nil
Parents Own Arrangements, Burial or Cremation <i>NB: If a baby is delivered with signs of life at any gestation ( even below 24 weeks) it is not included in a communal cremation service.</i>	Nil	There is no legal prohibition to parents requesting the return of the fetal remains	Parents own choice or via the hospital funeral undertaker. Burial or Cremation	Parents own choice or via the hospital funeral undertaker. Burial or Cremation	Parents own choice or via the hospital funeral undertaker. Burial or Cremation	Parents own choice or via the hospital funeral undertaker. Burial or Cremation

The Trust strives to offer sensitive care to bereaved families at the sad time of the loss of their baby. I will include in the response email to you some documentation which demonstrates the care that is taken by staff in dealing sensitively with grieving families which you may find helpful.



**Please note that the Trust had a Service Level Agreement in place with another hospital within the timeframe requested but these figures have not been included.**

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Information you receive which is not subject to crown copyright continues to be protected by the copyright of the person, or organisation, from which the information originated. You must ensure that you gain their permission before reproducing any third party (non Crown Copyright) information.

If you are unhappy with the service you have received in relation to your request please do not hesitate to contact me and I will try to resolve the situation, alternatively should you wish to make a complaint you can write to:

Elizabeth Radahd  
FOI Co-ordinator  
Wythenshawe Hospital  
Southmoor Road  
M23 9LT

Or you can email your comments to [FOI@uhsm.nhs.uk](mailto:FOI@uhsm.nhs.uk)

If you do make a complaint and find you are not content with the outcome, you may apply directly to the Information Commissioner for a decision. Generally, the ICO cannot make a decision unless you have exhausted the complaints procedure. The Information Commissioner can be contacted at:

Information Commissioner's Office  
Wycliffe House  
Water Lane  
Wilmslow  
Cheshire  
SK9 5AF.

If you have any queries about this letter, please contact me on the details above.

Kind regards

Yours sincerely

**Mandy Bailey**  
Chief Nurse

University Hospitals **NHS**  
Coventry and Warwickshire

NHS Trust

University Hospital  
Clifford Bridge Road  
Coventry  
CV2 2DX

Direct Telephone: 024 7696 8813  
Direct Fax: 024 7696 8786  
E-mail address: Linda.nelson@uhcw.nhs.uk

Our ref: LAN/1661

**Mr Guy Basnett**  
By email only: [foi.nhs@openworldnews.com](mailto:foi.nhs@openworldnews.com)

Dear Mr Basnett

We write further to your request for information under the Freedom of Information Act, and provide our response as detailed below.

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriage, stillbirth and abortion.

More specifically:

Q1.

- a) In 2012/13, how many fetuses/fetal remains from miscarriage, stillbirth and abortion were disposed of by the hospital?
- b) Please provide a breakdown by method of disposal, for example (but not limited to) buried separately, buried individually, incinerated, incinerated with clinical waste, cremated individually, cremated separately, passed to families for their own arrangements.
- c) For those incinerated or incinerated as clinical waste, please provide a list of locations where this was carried out.  
The location used for incineration of clinical waste by the Trust is Redditch.

Q2.

- a) b) and c) The same for 2011/12

The answer to Q1 & Q2 a) & b) are given in the table below:

Method of disposal	2011/12	2012/13
Individual burial	26	12
Shared grave	29	16
Monthly burial	64	49
Cremation	24	16
TOTAL	143	93

Fetal remains under 12 weeks gestation are sent for incineration. The figures are given in the table below:

Year	Number
2011/12	45
2012/13	85

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Victoria Demery, Business Support Manager, UHCW, Clifford Bridge Road, Coventry CV2 2DX.

If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

**Linda Nelson**  
**Freedom of Information Officer**

Ref: Response to request  
Date: 10<sup>th</sup> October 2013

**Information Governance  
Patient Services**  
Box number 153  
Addenbrooke's Hospital  
Cambridge Biomedical Campus  
Hills Road  
Cambridge CB2 0QQ

Mr G Basnett

Switchboard: 01223 245151  
Direct Dial: 01223 348697

Email: [foi.contact@addenbrookes.nhs.uk](mailto:foi.contact@addenbrookes.nhs.uk)  
[www.cuh.org.uk](http://www.cuh.org.uk)

Dear Mr Basnett

Thank you for your request for information, received on 12<sup>th</sup> September 2013.

I can confirm that we hold the information that you have requested.

I am writing under the Freedom of Information to request records of disposal of all fetal remains from miscarriages, stillbirths and abortions where fetal matter was present.

More specifically:

1. a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are incinerated with clinical waste, incinerated in groups, incinerated individually, cremated individually, cremated in groups, buried individually, buried in groups, or passed to families for their own arrangements.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide the a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.

2. a) b) and c) The same for 2011/12

Please see the attached document

If you are unhappy with this decision then please do not hesitate to contact me. Your concerns or complaint will be fully investigated and a response sent to you within 20 working days, in exceptional circumstances this may take longer.

If you are still dissatisfied with how your request has been dealt with then you have the right to appeal to the Information Commissioner. The Information Commissioner is the supervisory body that has been put in place to oversee the Freedom of Information Act 2000. You can write to Information Commissioners Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Belinda Bruty  
Data Awareness Manager

## **Freedom of Information Request for Information – September 2013**

### **Introduction**

Services are provided to ensure the sensitive disposal or funeral arrangements for all fetal remains following pregnancy loss, or following death of a baby.

Losses occur to due miscarriage, intrauterine death, termination of pregnancy, stillbirth or neonatal death.

A funeral is required by law for all pregnancy losses or death of a baby that occurs during pregnancy or after birth at 24 or more weeks of gestation.

A funeral is not required by law when there has been fetal loss or death of a baby before 24 weeks (when the baby was born with no signs of life).

The unique significance and social meanings in relation to fetal remains is recognised. Provision is made for sensitive disposal procedures. Also provision is made to assist patients who wish to make specific funeral arrangements and this is available for patients with no distinction made with regard to gestation.

Provision is made for patients to have choice regarding sensitive disposal and funeral arrangements.

### **Sensitive Disposal**

Note that fetal remains or fetal tissue are never incinerated with clinical waste

No burial in groups takes place

Sensitive disposal takes place when patients request hospital based sensitive disposal. This provides for patients who wish for hospital arranged sensitive disposal with all cases identification anonymised, and also each arrangement may be individually audited.

In this way then under 13 weeks gestation provision is made for sensitive disposal of fetal remains by specific supervised incineration. Specific provision is always made for the sole incineration of fetal tissue, under supervision of Paediatric Pathology team and with the Hospital Lead Chaplain present.

In this way too sensitive disposal of fetal remains above 13 weeks gestation takes place when patients request hospital arranged sensitive disposal. Provision is made for sensitive disposal by cremation is made to take place in the Cambridge City Crematorium with the Lead Hospital Chaplain present. This is a group cremation.

### **Sensitive Disposal at the hospital site**

We are unable to provide data prior to February 2012  
Feb 2012- Dec 2012 - 462

Jan 2013-Sept 2013 - 335

### **Sensitive Disposal Service at the Crematorium**

July 2013-20

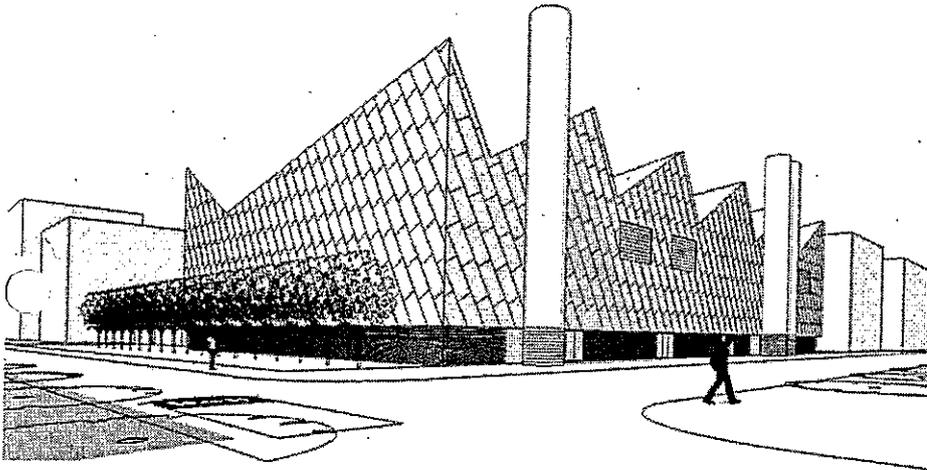
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# New energy innovation centre for Addenbrooke's hospital to generate carbon savings

21 May 2012

Cambridge University Hospitals (CUH) has appointed MITIE preferred bidder status to develop a major new energy innovation centre.

The new energy innovation centre will service Addenbrooke's and Rosie hospitals and potentially future developments on the Cambridge Biomedical Campus. It will be developed in partnership with MITIE and the NHS Carbon and Energy Fund.



The new energy centre will provide heating, hot water and electricity and reduce the Trust's carbon footprint by 30,000 tonnes of CO<sub>2</sub> a year, helping CUH to surpass sustainability targets. This will mean a 47 per cent cut in carbon emissions over the 25 year contract term.

The Trust's existing energy centre houses the NHS's first combined heat and power plant which, for the last 20 years, has been providing sustainable energy to the expanding campus. The Trust incinerates its clinical waste onsite within the energy centre and uses clinical waste produced on the campus as a fuel source to provide heat and hot water to the campus.

With advances in technologies, the new energy centre which will house a brand new incinerator, a highly efficient Rolls Royce combined heat and power plant and will also use wood chip as a fuel source.

Besides developing and operating the energy centre, MITIE will invest in reducing energy demand on the existing CUH campus through a number of initiatives including a major lighting upgrade throughout the hospital.

John Charlton, Director of Estates and Facilities Management at CUH said: "This is a very exciting project which enables us to cut our carbon footprint significantly, reduce our reliance on fossil fuels, and exceed our sustainability targets. By utilising a number of different energy efficient technologies we can potentially deliver this low carbon, low cost energy to further NHS development on the Biomedical Campus."

Mike Tivey, Managing Director of MITIE's Asset Management division, said: "This will be a state-of-the-art energy centre which will deliver significant economic and sustainability benefits. In an increasingly volatile energy environment this will provide Cambridge University Hospitals with increased energy resilience and predictably priced energy over the long term."

Construction is expected to start at the end of the year and the new energy centre will be fully operational by 2015.

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## Facts

The Carbon and Energy Fund funds and supports projects in the NHS which meet a certain level of carbon savings.

The energy centre will mean almost 30,000 tonnes of CO<sub>2</sub> will be saved a year, equating to a total cut in current carbon emissions by 47 per cent

The carbon savings of the energy centre will help Addenbrooke's surpass its NHS sustainability targets by 27 per cent.

A 50 per cent reduction in energy consumption is expected to be achieved over 25 years by the new centre.

# Energy innovation centre for CUH moves a step closer

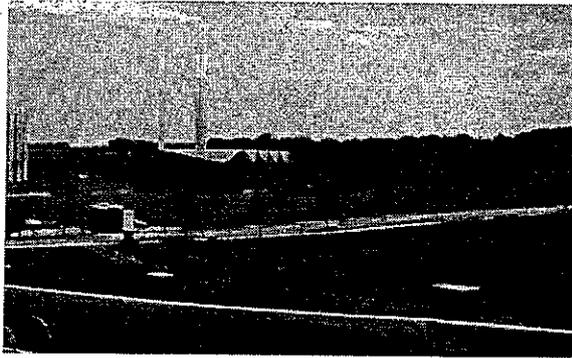
19 July 2013

A major new energy innovation centre which will deliver significant carbon and cost savings for Cambridge University Hospitals (CUH) has passed a milestone with the approval of planning permission.

The energy innovation centre, which is expected to be one of the largest projects of its type in the UK, will provide low carbon heating, hot water and electricity for the Addenbrooke's and Rosie hospitals. It has been designed with the potential to provide energy to future developments on the Cambridge Biomedical Campus.

The new energy centre aims to reduce CUH's carbon footprint by 30,000 tonnes of CO<sub>2</sub> a year, helping the Trust to surpass sustainability targets. This could mean a 47 percent cut in carbon emissions over the 25 year contract term. Grid electricity will be cut by more than 50 per cent.

St.Clair Armitage, CUH director for corporate development, said: "We are very pleased that this excellent project has received planning permission from the county council. Subject to further approvals, the energy innovation centre will deliver significant economic and sustainability benefits for CUH and our partners on the Cambridge Biomedical Campus. The low carbon, state-of-the-art energy centre will provide us with greater energy independence and reduce the impact of rising energy prices."



Artist's impression of the new energy centre

MITIE was awarded the contract to develop and operate the energy innovation centre in March last year. It will be developed in partnership with the NHS Carbon and Energy Fund which supports projects which meet a certain level of carbon savings.

Following planning approval from Cambridge County Council, Utiyix, MITIE's integrated energy solutions business, will start work on the energy centre next Spring. The 2,675sqm energy innovation centre will be fully operational by 2015.

The new energy innovation centre will house a combined heat and power unit, biomass boiler, efficient dual fuel boilers and heat recovery from clinical waste incineration.

Mark Stokes, managing director of Utiyix's asset management division, said: "This is a major milestone for this important project which will have a material impact on Cambridge University Hospital's carbon emissions and energy costs. We're really excited about moving forward and enabling the energy innovation centre in partnership with Cambridge University Hospitals."

The Trust's existing energy centre houses the NHS's first combined heat and power plant which, for the last 20 years, has been providing sustainable energy to the expanding campus. The Trust incinerates its clinical waste onsite within the energy centre and uses clinical waste produced on the campus as a fuel source to provide heat and hot water to the campus.

Besides the development of the energy centre, Utiyix will also reduce energy demand on the existing CUH campus through a number of initiatives including a major lighting upgrade throughout the hospital.

Peter Brett Associates LLP (PBA) led the pre-application work for the project, providing town planning and Environmental Impact Assessment advice and coordination. The consultancy produced a number of assessments including air quality, noise, transport, drainage and flood risk, waste, and ground conditions work.

John Parmitar, PBA partner, said: "We are very proud to be involved in such a significant project. This builds further on our experience in the renewable energy sector."

## On this site:

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Dear Mr Basnett,

Thank you for your request under the Freedom of Information Act (FOI).

You requested:

1.a) In 2012/13, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)? 686

1. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are:

0 incinerated with clinical waste, 599 incinerated in groups, 0 incinerated individually, 41 cremated individually, 0 cremated in groups, 24 buried individually, 0 buried in groups, or 22 passed to families for their own arrangements.

1. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites. Ipswich Hospital

2. a) b) and c) The same for 2011/12

2 a) In 2011/12, how many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)? 550

2. b) Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups. My category suggestions are:

incinerated with clinical waste 0, incinerated in groups 502, incinerated individually 0, cremated individually 26, cremated in groups 0, buried individually 16, buried in groups 0, or passed to families for their own arrangements 16.

2. c) For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites. Ipswich Hospital

Hopefully this answers your request.

If you are dissatisfied with the way Colchester Hospital University NHS Foundation Trust has handled your request for information, you can request a review by writing to :

*The Senior Information Risk Owner  
Colchester Hospital University NHS Foundation Trust  
Trust Headquarters  
Colchester General Hospital  
Turner Road  
Colchester, Essex, CO4 5JL*

*If you remain dissatisfied with the handling of your request or complaint, you have a right of appeal to the Information Commissioner at:*

*The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.*

*Telephone: 08456 30 60 60 or 01625 54 57 45 Website: [www.ico.gov.uk](http://www.ico.gov.uk)*

*There is no charge for making an appeal.*

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*If you have any ideas on how to improve our FOI service or changes that you'd like to see, then please submit a Feedback Form at [www.colchesterhospital.nhs.uk/foi\\_feedback.shtml](http://www.colchesterhospital.nhs.uk/foi_feedback.shtml). These can be completely anonymous and will help us to provide a better service in the future.*

*Kind Regards*

*The FOI Team at Colchester Hospital University NHS Foundation Trust*

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Colchester Hospital University NHS Foundation Trust, Turner Road, Essex, CO4 5JL

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<b>Committee:</b>	Development Control Committee
<b>Meeting Date:</b>	7 September 2006
<b>Local Councillor/s:</b>	Cllr Russell Harsant
<b>Director:</b>	Lucy Robinson, Director of Environment and Transport
<b>Assistant Director or Head of Service:</b>	David Palk, Head of Development Control 01473 264771
<b>Author:</b>	Martin Chiverton, 01473 264766

### **MINERALS AND WASTE PLANNING APPLICATIONS**

**IP/06/00582/FPC:** Bin storage facility and transport office. Ipswich Waste-to-Energy Plant, Incinerator Building, Woodbridge Road East, Ipswich

**Applicant:** White Rose Environmental Ltd

**Plans displayed:** Drawing No. 05021/GA Rev B

### **BRIEF SUMMARY OF REPORT**

1. This report deals with a planning application for the construction of a single storey building to provide secure storage for waste bins at Ipswich Hospital waste incinerator.
2. There has been one objection.
3. The report recommends conditional approval.

### **ACTION RECOMMENDED**

4. It is recommended that planning permission is granted subject to the following condition:
  1. CM2 Compliance with conditions.

### **REASON FOR RECOMMENDATION**

5. To exercise planning control having regard to policy and material planning considerations.
6. The proposed building is necessary to comply with Environment Agency requirements for the secure storage of clinical waste bins.
7. It will provide a single storage point for bins, with no detrimental environmental effects.

### **ALTERNATIVE OPTIONS**

8. None.

## **MAIN BODY OF REPORT**

### **BACKGROUND**

9. The waste-to-energy plant at Ipswich Hospital incinerates clinical waste from several sources, utilising the heat generated to provide the hospital with heating and hot water. Waste is delivered in wheeled bins. Most are stored within the building but at peak times or during maintenance or breakdown, it is sometimes necessary to store them in the open.
10. The Environment Agency now requires all full bins to be stored in secure facilities.

### **PROPOSAL**

11. The proposal is for the construction of a single storey building capable of storing up to 168 clinical waste bins. It would be 32 metres long and 5.4 metres deep. Maximum height of the flat roof would be 3 metres. It would have lockable steel gates along its entire frontage. The rear wall would be formed by raising the height of an existing concrete wall with steel mesh.
12. Also included in the application is a portacabin-type office measuring 4.8 metres by 2.7 metres.
13. Both buildings would be erected along one side of an area to the west of the incinerator building, which is currently used mainly for open-air bin storage, but also used for occasional overflow car parking and general storage.

### **POLICY**

#### **Waste Local Plan**

##### **14. WLP2**

Waste management development will only be acceptable where it can be demonstrated that it is compatible with existing or proposed neighbouring land uses, would not cause significant harm to the environment, residential or rural amenity and would not unacceptably harm human health or safety.

Conditions will be attached to planning permissions or legal agreements entered into to ensure satisfactory control of environmental impacts. Waste development will not be acceptable where impacts cannot be satisfactorily controlled.

Where waste development proceeds which will adversely impact on areas of recognised environmental importance significant prior measures to mitigate the impacts and/or provide appropriate environmental improvements will be required.

### **REPRESENTATIONS**

#### **D Saunders, Heath Road**

15. No objection provided the new building is no higher than the present incinerator building and does not harbour flies or rats.

## **J Soilleux, Heath Road**

16. Objects on the grounds of:
  - a) Effect on property value, due to night-time noise from the boiler and ashes on the car in the mornings.
  - b) As waste will eventually come from all over the country the storage bins will never be large enough. Bins are currently stored in several places. The storage facility will not be large enough, damaging the environment through noise, pollution and smell.

## **CONSULTATIONS**

### **Noise and Air Pollution Manager**

17. Ipswich Borough Council's Environmental Health Officer has not received any complaints relating to bin storage in recent times. I am therefore satisfied that current activity on the site is not causing a noise nuisance either during the day or during the night-time period, which is likely to be the most sensitive.
18. The location of the proposed bin storage facility is well away from the nearest dwellings and is shielded from them by the hospital buildings and I would therefore not anticipate that a noise problem would arise. Since this facility will regularise the storage of bins within one area that is shielded from dwellings, it may result in a slight reduction in the potential for a noise nuisance to be caused.
19. On the basis of the above, I do not recommend that any noise control conditions be imposed for this application.

### **Environment Agency**

20. No objection.

### **Ipswich Borough Council**

21. No objection.

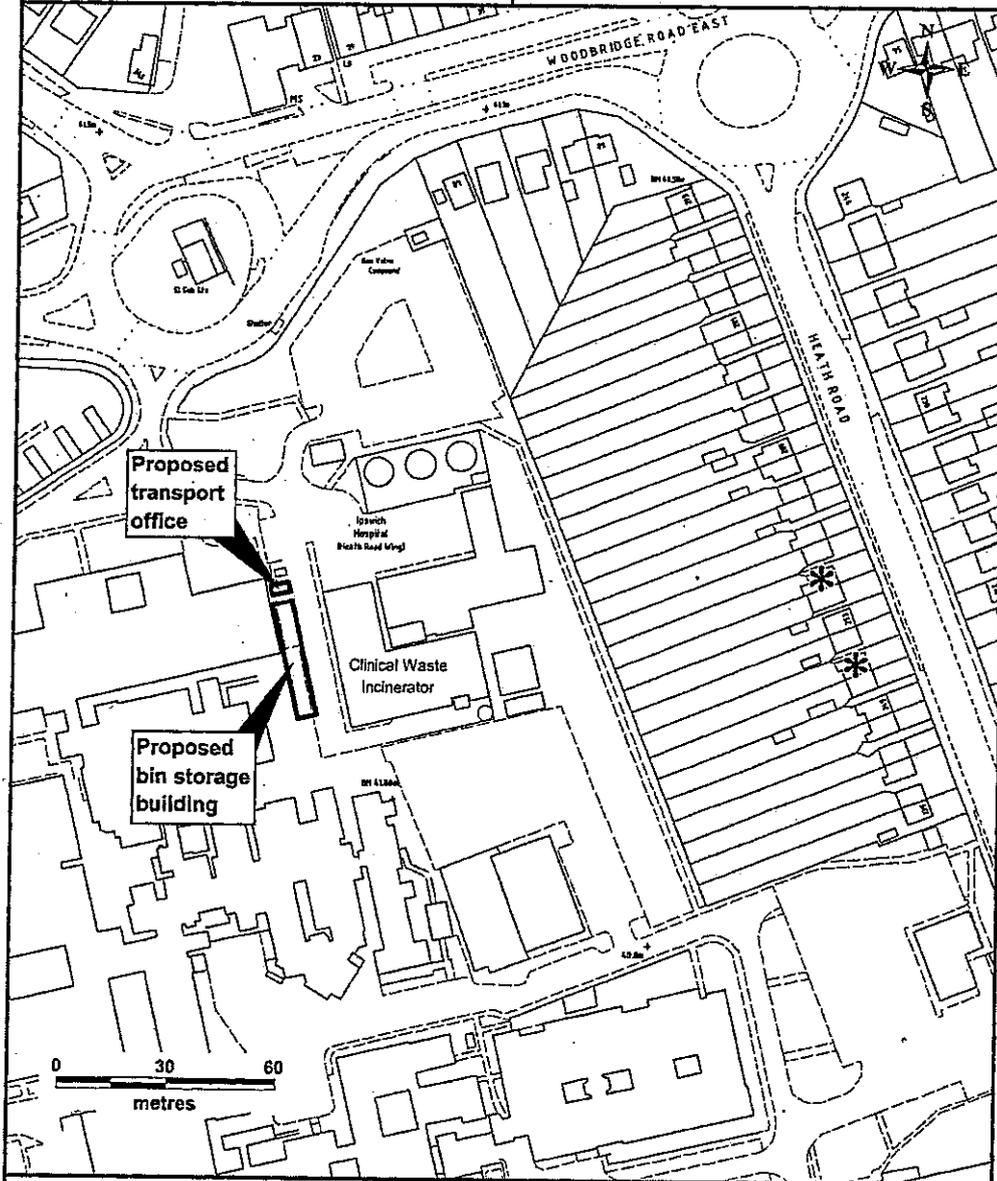
## **COMMENTS OF THE HEAD OF DEVELOPMENT CONTROL**

22. The development is reasonable and necessary to comply with a new Environment Agency requirement that bins containing clinical waste must be stored in a secure building whilst awaiting transfer to the adjacent incinerator facility.
23. The new building will have negligible physical impact on its surroundings, being screened on three sides by much taller buildings related to the service areas of the hospital. It will be hardly visible from the nearest public viewpoint on Woodbridge Road East.
24. The new building will provide a single storage point for clinical waste bins and reduce or eliminate the likelihood of bins being stored at other locations further from the incinerator. By virtue of its location alongside the incinerator building, the chances of noise disturbance from the movement of bins would be reduced. The building's capacity has been dictated by the Environment Agency based on licensed maximum throughput and any suggestion that it is too small is unfounded.

25. The development would have no impact on smell or vermin; the storage bins are galvanised steel with sealed lids. These are in any case matters for control by the Environment Agency or Ipswich Borough Council's Environmental Health Officer.

**SOURCES OF FURTHER INFORMATION**

- a) Correspondence received between 19 May 2006 and 7 September 2006 held on file IP/06/00582/FPC.



KEY

\* Representations

**Bin Storage Facility  
and Transport Office:  
Waste-to-Energy Plant**



**Suffolk County Council  
Environment & Transport**

**IP/06/00582/FPC  
IPSWICH**

Lucy Robinson  
Director of Environment & Transport  
Endeavour House, 8 Russell Road, Ipswich, Suffolk, IP1 2BX.

Question 1:

Number of foetuses/foetal remains from miscarriages, stillbirths and abortions disposed of by the hospital

01/04/11 to 31/03/12	288
01/04/12 to 31/03/13	218

Question 2:

Breakdown by method of disposal

Disposal Method	01/04/11 to 31/03/12	01/04/12 to 31/03/13
Hospital Cremation	247	167
Hospital Burial - individual	11	12
Incineration	19	24
Return to family - individual	11	15

Hospital cremation is dependent on gestation:  
Up to 11 weeks +6 days individually wrapped and cremated in groups  
Above 12 weeks all cremated individually

Incineration is only offered up to 11 weeks + 6 days

Question 3:

Location where clinical waste is incinerated

SRCL Bournemouth  
Waste to Energy Facility  
Royal Bournemouth Hospital  
Bournemouth  
Dorset  
BH7 7DW

Question 4:

Information for 2011/12 - see above

## Patient information and consent to medical management of miscarriage

### Key messages for patients

- **Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your procedure/treatment.**
- **Please read this information carefully**, you and your health professional will sign it to document your consent. Please bring this consent form with you to the hospital on the day of your procedure/treatment.
- Please bring with you any medications you use (including patches, creams and herbal remedies) and any information that you have been given relevant to your care in hospital, such as x rays or test results.
- Take your medications as normal on the day of the procedure **unless** you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team.
- Please call the Early Pregnancy Unit on Daphne Ward on **01223 217636** if you have any questions or concerns.

After the procedure we will file the consent form in your medical notes and you may take this information leaflet home with you.

### Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure/treatment has started (as long as it is safe and practical to do so).

We will also only carry out the procedure/treatment on your consent form unless, in the opinion of the responsible health professional, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be ~~procedures/treatments you do not wish us to carry out and these can be recorded on~~ the consent form. We are unable to guarantee that a particular person will perform the procedure/treatment. However the person undertaking the procedure/treatment will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998.

## About medical management of miscarriage

- Sadly your pregnancy has resulted in miscarriage. We are very sorry that this has happened. Miscarriage in early pregnancy is very common, with as many as one in four confirmed pregnancies ending this way.
- After a miscarriage, there can be some tissue and / or blood clot left in the uterus (womb). There are three ways in which to manage this condition:
  - The tissue and / or blood clot may pass naturally (**Conservative/ Expectant management**)
  - We can perform an operation to remove this (**Surgical management**)
  - You can also have medication to empty the womb (**Medical management**).

You have chosen medical management.

Medical management of miscarriage is a process like a natural miscarriage and as such involves bleeding and some pain.

The treatment consists of taking a tablet of mifepristone, by mouth, which blocks the action of progesterone, a hormone necessary for the pregnancy to remain attached to the wall of the uterus (womb).

This is followed two to three days later by the use of other tablets misoprostol (a prostaglandin) which causes the uterus to expel the pregnancy. These drugs are put into the vagina, near the cervix (neck of the womb). For this part of the treatment you are admitted onto the Early Pregnancy Unit (Daphne ward) for the day.

## Intended benefits

- To remove any remaining tissue and blood clot in the uterus (womb) after a miscarriage
- Avoids an operation and general anaesthetic
- Some women feel more in control when undergoing medical treatment as opposed to surgical treatment
- Some women feel that consciously experiencing the miscarriage benefits them in terms of grieving for their lost baby. (Smith et al 2006)
- Natural process but more manageable than waiting for nature to take its course.

## Disadvantages of the procedure

- Some women find the procedure prolonged; you may not miscarry whilst in hospital.
- Some women find the pain of the procedure unacceptable although the nursing staff will give you pain relief to help you with this. The level of pain is individual; some equate it with labour others with a bad period pain.

- Some women find the amount of bleeding is unacceptable with it being heavier than a period, other women cope well. Some fear seeing the fetus.
- The treatment regime may have side effects such as nausea, vomiting and diarrhoea, dizziness and hot flushes.
- The procedure can be perceived as frightening so we try to give you as much information as possible to alleviate your fears.
- Bleeding can continue for up to three weeks.
- May still require surgical intervention.

**Who will perform my procedure?**

The nursing staff will administer the medication to you.

**Before your procedure**

Most patients are seen on the early pregnancy unit, when you will meet one of the nurses/doctor. At this time, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask us any questions about the procedure/treatment, and feel free to discuss any concerns you might have at any time.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring any packaging with you.

It is important that you tell the nurse or doctor looking after you about any previous or current health problems you have, in particular raised blood pressure, heart disease, asthma, liver or kidney disease or a problem with blood clotting.

**First appointment –taking the mifepristone**

**Please come to Daphne ward between 10:00 – 16:00 hours**

On .....day, date.....

**Taking the Mifepristone tablet**

A member of the nursing team will ensure that you are not feeling nauseous. If you have been suffering from morning sickness, we will give you an anti-sickness tablet, prior to the Mifepristone, because some women may feel more nauseous having taken the drug.

Once you have taken the Mifepristone you will be asked to remain on the ward for a further 20 to 30 minutes, to ensure you have managed to keep the tablet down and not vomited.

**Things to avoid:**

- Smoking
- Alcohol
- Non-steroidal anti inflammatory drugs (such as aspirin, ibuprofen, diclofenac (Voltarol) or mefenamic acid (Ponstan))

Avoid these until after the second part of the treatment. All will reduce the effectiveness of the medication and may make any symptoms of nausea worse.

**What to expect over the next 48 hours or until your admission for the second part of the treatment**

**Bleeding:** You may start to bleed before your next visit, or any bleeding you already have may increase. Try not to worry. It is advisable to use sanitary towels rather than tampons as this reduces any risk of infection. If you are concerned that the bleeding is excessive (requiring you to change a sanitary pad every half an hour) please telephone either **Daphne ward** or the **Inpatient Gynaecology Ward** for advice (see contact numbers later in this leaflet)

**We understand that bleeding heavily at home can be frightening. Please do not hesitate to contact us if you are unsure what to do.**

**Discomfort/pain:** Some women experience cramp-like discomfort, similar to period pains. You **must not** take: Aspirin, mefenamic acid (Ponstan), diclofenac (Voltarol) or Ibuprofen. It is better to use paracetamol or codeine based painkillers.

**Miscarriage risk:** Some women have heavy blood loss at home and actually miscarry before coming in for the second course of treatment. If this happens we advise you to still attend for the treatment, as we cannot be sure that the miscarriage is complete and an ultrasound scan at this time would **not** be beneficial. By continuing with the treatment regime your chances of future problems, such as infection caused by retained products of conception, will be reduced.

**Second appointment - Admission for the misoprostol (prostaglandin) treatment**

Please come to Daphne ward at **08:30 hours** on ..... day,  
date.....

**Have a light breakfast beforehand.**

**Before your procedure**

- **What do I need to bring?** Wear loose, comfortable clothes and bring spare clothing and underwear with you. You cannot use tampons but you can provide your own sanitary towels if you prefer, though please do not use the highly absorbent type (for example: 'Always') as they make it difficult to check how

much you are bleeding. Please bring items such as a toothbrush and nightwear in case you need to stay in overnight.

- You will have access to your own television and telephone via pay cards. The radio is free. Bring in some magazines or something else to pass the time. There are water dispensers and a hot-drinks machine that you can help yourself to throughout the day. These facilities are free. In addition we will provide you with a light lunch such as sandwiches about midday.
- **Can I bring someone with me?** You can bring your partner or one friend with you, and they are very welcome to stay throughout the day. They are welcome to use the drink facilities but please note we do not provide food for them – there are facilities within the hospital campus; the ward staff will give them directions. We prefer that you do not leave the ward whilst the treatment is in progress as you may feel unwell. Please note that we do not have the facilities to care for children or to have them for long periods of time on the ward as it disturbs other patients. Please make your own arrangements for child-care before attending the hospital.

## During the procedure itself

### The Misoprostol (prostaglandin) treatment

- Your nurse will go through the procedure with you. After a few checks she will insert the misoprostol (prostaglandin) tablets into your vagina. You will need to remain on the bed for one hour after this to allow the tablets to stay in place and thereby start to work. The tablets cause your womb to contract, and these contractions will feel like strong period pains. If you can, it is best to try and tolerate some discomfort, as this will make the treatment work more quickly, but your nurse will give you painkillers when you need them. The tablets can cause some side-effects such as diarrhoea, nausea, dizziness and hot flushes. The side-effects do not last for very long, and if you have any of these symptoms the nurses will do all they can to make sure you are as comfortable as possible.
- Occasionally at the end of the procedure, if the tissue is not expelled from the womb then it is necessary to do a small operation to remove it (surgical management). If this is done it will be performed under general anaesthetic and you will need to stay overnight.
- It is very important that the nurses check to see what you are passing. You will be asked to pass water or open your bowels into a cardboard bedpan that fits into the toilet bowl. You must not flush anything down the toilet. You will not have to see anything that comes away although it is possible that you may do; the nurses will be on hand to take away any bedpans that you may have used. If you change your sanitary towel please show it to the nurse before putting it in the bin. This will help us monitor your blood loss accurately.

## After the procedure



**Eating and drinking.** You can eat and drink as long as you are not feeling sick. It is best to have only a light diet during the day.



**Getting about after the procedure/treatment.** You can walk around the ward if you wish after the first hour and this may help the treatment work more quickly. Please do not leave the ward without speaking to your nurse first and as previously mentioned we would prefer that you stayed on the ward for the duration of the treatment.



- **Leaving hospital.** You will not be discharged until the miscarriage is complete or a further management plan is in place. You may require an examination before you go, and your nurse will do a final check and give you discharge advice.

- It is sensible to have someone travel home with you and stay with you overnight. You should be able to leave the ward by late afternoon / early evening, but please remember that rarely some patients have to stay overnight. In case this happens, you should make any necessary arrangements beforehand. This is especially important if you have children at home who will need to be cared for.



- **Resuming normal activities including work.** Most women prefer to take the following day off work, both for their emotional and physical recovery. If you feel you need longer you are able to self certificate for up to five days. If you have another child at home we suggest you have another adult around to assist you as you may be sleepy.

- **Emotional impact:** Women react in different ways to a miscarriage: some women come to terms with what has happened within a few weeks, others can take much longer. It is normal to feel tearful and sad, angry or even guilty. Losing a baby can be a very painful experience for partners too, and sometimes their grief is unacknowledged.



- **Special measures after the procedure/treatment:**

- Women whose blood group is rhesus negative will be given an injection of anti-D before leaving to protect future pregnancies from being affected by rhesus incompatibility.

- **Pain:** You may have period-like pains for a few days; this is normal. Simple painkillers that you can buy over the counter such as paracetamol and ibuprofen should help this. You are now allowed to use the non-steroidal medications that we advised you avoid after the first part of the treatment. If your pain is not relieved by this medication then please contact us on the numbers below.

- **Vaginal bleeding:** You may have some vaginal bleeding for up to three weeks following the procedure and we advise you to use sanitary towels and not tampons. Avoid sexual intercourse or swimming until the bleeding has stopped. This is to help prevent any infection. The bleeding is like a heavy period for the first day or so but this will lessen over time

and you may even have a brown discharge before it stops completely. We also suggest that you avoid long soaks in the bath and use a shower instead; ensure someone is around when you do this in case the hot water makes you feel faint / dizzy. Should you have concerns that your bleeding is not settling or you have a fever and 'flu-like' symptoms then contact your GP (General Practitioner) or contact us on the numbers below.

- **Next period and future pregnancies:** Your next period may happen in four to six weeks after the procedure. Prior to this you will have ovulated and therefore will be able to become pregnant again. The manufacturers of mifepristone recommend you delay any future pregnancies until after your next period. You may therefore wish to consider some form of contraception. Please see your General Practitioner (GP) for this.
- **Check-ups and results:** Unless you are otherwise told, you will not be contacted specifically by the Early Pregnancy Unit (EPU) following the procedure. However, if you have any concerns or questions you can telephone them directly.
- If this is not your first miscarriage and you meet certain criteria you may be referred to the recurrent miscarriage clinic. This may involve your having additional tests before this appointment. The staff on the Early Pregnancy Unit will discuss this with you.

**Do I need to inform anyone about my miscarriage?** No. Staff on Daphne ward will have written to your General Practitioner (GP) and community midwife and any antenatal scans or appointments will have been cancelled, so you do not need to worry about doing this.

### Significant, unavoidable or frequently occurring risks of this procedure/ treatment

If you have a pre-existing medical condition, are obese or have had previous surgery the quoted risks for serious or frequent complications will be increased.

The table below is designed to help you understand the risks associated with this type of surgery (based on the RCOG Clinical Governance Advice, Presenting Information on Risk).

Term	Equivalent numerical ratio	Colloquial equivalent
Very common	1/1 to 1/10	A person in family
Common	1/10 to 1/100	A person in street
Uncommon	1/100 to 1/1000	A person in village
Rare	1/1000 to 1/10 000	A person in small town
Very rare	Less than 1/10 000	A person in large town

Medical Management of miscarriage is a very safe procedure, however, like all procedures there are potential risks involved. Your gynaecologist and nurse will ensure that the appropriate measures are taken to reduce the risk of complications. The main risks of the procedure are:

- Complications are rare, but may include excessive vaginal bleeding requiring transfusion (uncommon 1 in every 100)
- Infection risk is low (uncommon 1 in every 100)
- Rarely, women do not pass all of the tissue and / blood clot following the prostaglandin. If this happens, the whole procedure can be repeated or an operation may be required (uncommon 1 in every 100)
- There is a rare chance some of the retained tissue and /or blood clot will not all be expelled and you may require a further a repeat dose (common - up to 5 in 100 women).

### **What happens to any tissue or the fetus?**

Any tissue or the fetal parts are sent to the histopathology laboratory to confirm the miscarriage.

No other investigations are usually carried out into the cause of the miscarriage at this time unless specifically discussed with you.

### **Further arrangements**

There are standard procedures in place for the disposal of fetal remains following miscarriages which are described briefly below. If you wish to obtain more detailed information of the processes, please contact one of the people named at the end of this document:

- Fetal remains below 13 weeks gestation are cremated within the hospital, in accordance with the relevant code of practice. This is planned and organised to ensure that no other material is dealt with at the same time. The process is witnessed by two members of the bereavement team.
- Fetal remains above 13 weeks gestation are cremated at the local crematorium in a monthly group service taken by the lead Chaplain for the Trust. In order to maintain patient confidentiality the patient's name is not used to identify the remains.
- A woman or couple may decide to make arrangements themselves, either at home or in a local cemetery/crematorium using a funeral director. To arrange this please contact one of the people listed below, prior to the procedure.

If you wish to discuss any of the above, or to have further information, please contact Daphne Ward staff (01223 217636) or one of the chaplaincy team (01223 217769).

## Alternative procedures or treatments that are available

- If the bleeding is not excessive, and you prefer not to have an operation, you might wish to wait and allow the womb to expel the remaining tissue without assistance (**expectant management**).
- You might choose to have **surgical management**, when you have an operation under general anaesthetic to empty the uterus (womb). This may be slightly more effective than the medical treatment you are having but there are higher risks involved. Surgical management is not recommended if your pregnancy was below seven weeks (gestation) or if the retained products / blood clots that were seen on your scan are too small to require surgical intervention.



### Information and support

You might be given some additional patient information before or after the procedure, for example: leaflets that explain what to do after the procedure and what problems to look out for.

If you have any questions or anxieties, please feel free to ask a member of staff including staff on:

- The Early Pregnancy Unit, Daphne Ward  
01223 217636  
Open 08.00 – 20.00 Monday to Friday and 08.30 – 14.00 at weekends  
Closed Bank holidays
- Inpatient Gynaecology ward  
01223 348544  
At all other times

#### Other useful sources of support:

- The Miscarriage Association  
01924 200799 (Monday-Friday 09:00 – 16:00)  
[www.miscarriageassociation.org.uk](http://www.miscarriageassociation.org.uk)
- The Royal College of Obstetricians and Gynaecologists  
Recovering Well Patient Information  
[www.rcog.org.uk](http://www.rcog.org.uk)  
[Early miscarriage: information for you \(pdf\)](#)

## Information about important questions on the consent form

### 1 Photography, Audio or Visual Recordings

As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

### 2 Students in training

Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.



### Privacy & Dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.



We are currently working towards a smoke free site. Smoking is only permitted in the designated smoking areas. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169



### Help with this leaflet



If you would like this information in **large print**, another language or in audio format, please ask the department to contact Patient Information on 01223 216032 or [patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)

### Document history

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# Consent Form

## Medical management of miscarriage

For staff use only:

Hospital number:

Surname:

First names:

Date of birth:

NHS no: \_\_\_ / \_\_\_ / \_\_\_

Use hospital identification label

**A** Patient's side left / right or N/A

### Consultant or other responsible health professional

Name and job title: .....

Any special needs of the patient (e.g. help with communication)? .....

Please use 'procedure completed' stamp on completion of procedure/treatment where applicable

### **B** Statement of health professional (details of treatment, risks and benefits)

**1** I confirm I am a health professional with an **appropriate knowledge of the proposed procedure/treatment**, as specified in the hospital's consent policy. I have explained the procedure/treatment to the patient. In particular, I have explained:

**a)** the intended benefits of the procedure/treatment (please state)

- Remove any remaining tissue and blood clot in the uterus (womb).
- Avoids an operation and general anaesthetic
- Some women feel more in control when undergoing medical treatment as opposed to surgical treatment
- Experiencing the miscarriage benefits some women in terms of grieving for their lost baby. (Smith et al 2006)
- Natural process.

**b)** the possible risks involved. Addenbrooke's always ensures any risks are minimised. However all procedures/treatments carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient

- Excessive vaginal bleeding requiring transfusion (uncommon 1 in every 100)
- Infection risk is low (uncommon 1 in every 100)
- Rarely, women do not pass all of the tissue and / blood clot following the prostaglandin. If this happens, the whole procedure can be repeated or an operation may be required (uncommon 25 in every 100)
- some of the retained tissue and /or blood clot will not all be expelled and you may require a further a repeat dose (common - up to 5 in 100 women).

**c)** what the procedure/treatment is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:

# Consent Form

## Medical management of miscarriage

For staff use only:

Hospital number:

Surname:

First names:

Date of birth:

NHS no: \_ \_ \_ / \_ \_ \_ / \_ \_ \_ \_

Use hospital identification label

d) any extra procedures/treatments that might become necessary during the procedure/treatment such as:  Blood transfusion  Other procedure/treatment (please state)

The following information leaflet has been provided:

### Medical management of miscarriage

Version, reference and date: **CF245 v7 February 2013**

or  I have offered the patient information about the procedure/treatment but this has been declined.

3 This procedure/treatment will involve:

General and/or regional anaesthesia  Local anaesthesia  Sedation  None

Signed (Health professional): ..... Date: D.D / M.M / Y.Y.Y.Y

Name (PRINT): ..... Time (24hr): ..... M.M : M.M

Designation: ..... Contact/bleep no: .....

## C Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure/treatment have been discussed with me and that my questions have been answered to my satisfaction and understanding.

**Important:** please read the patient information about this procedure/treatment and then put a tick in the relevant boxes for the following questions:

### 1 Photography, Audio or Visual Recording

a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.  Yes  No

b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.  Yes  No

### 2 Students in training

I agree to the involvement of medical and other students as part of their formal training.  Yes  No

# Consent Form

## Medical management of miscarriage

For staff use only:

Hospital number:

Surname:

First names:

Date of birth:

NHS no: \_\_\_ / \_\_\_ / \_\_\_

Use hospital identification label

**3** Insert here any other details /consents required

I have listed below any procedures/treatments that I do not wish to be carried out without further discussion.

I have read and understood the Patient Information about this procedure/treatment and the above additional information. I agree to the procedure or treatment.

Signed (Patient): ..... Date: DD/MM/YYYY

Name of patient (PRINT): .....

*If signing for a child or young person; delete if not applicable.*

I confirm I am a person with **parental responsibility** for the patient named on this form.

Signed: ..... Date: DD/MM/YYYY

Relationship to patient: .....

*If the patient is unable to sign but has indicated his/her consent, a witness should sign below.*

Signed (Witness): ..... Date: DD/MM/YYYY

Name of witness (PRINT): .....

Address: .....

# Consent Form

## Medical management of miscarriage

For staff use only:

Hospital number:

Surname:

First names:

Date of birth:

NHS no: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Use hospital identification label

### D Confirmation of consent

**Confirmation of consent** (where the procedure/treatment has been discussed in advance)

On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the procedure/treatment to go ahead.

**Signed** (Health professional): ..... Date: ..D.D./M.M./Y.Y.Y.Y.....

**Name** (PRINT): ..... **Job title:** .....

**Please initial to confirm all sections have been completed:** .....

### E Interpreter's statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

**Signed** (Interpreter): ..... Date: ..D.D./M.M./Y.Y.Y.Y.....

**Name** (PRINT): .....

Or, please note the language line reference ID number: .....

### F Withdrawal of patient consent

The patient has withdrawn consent (ask patient to sign and date here)

**Signed** (Patient): ..... Date: ..D.D./M.M./Y.Y.Y.Y.....

**Signed** (Health professional): ..... Date: ..D.D./M.M./Y.Y.Y.Y.....

**Name** (PRINT): ..... **Job title:** .....

## Patient information and consent to surgical management of miscarriage

### Key messages for patients

- **Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.**
- **Please read this information carefully**, you and your health professional will sign it to document your consent.
- **It is important that you bring the consent form with you when you are admitted for surgery.** You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.
- **Please bring with you any medications you use (including patches, creams and herbal remedies)** and any information that you have been given relevant to your care in hospital, such as x rays or test results.
- Take your medications as normal on the day of the procedure **unless** you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. **Do not** take any medications used to treat diabetes.
- Please call the Early Pregnancy Unit (Daphne Ward) on telephone number **01223 217636** if you have any questions or concerns about this procedure or your appointment.

After the procedure we will file the consent form in your medical notes and you may take this information leaflet home with you.

### Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.

We will also only carry out the procedure on your consent form unless, in the opinion of the responsible health professional, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998.

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## About surgical management of miscarriage

Sadly your pregnancy has resulted in a miscarriage. We are very sorry that this has happened. Miscarriage in early pregnancy is very common, with as many as one in four confirmed pregnancies ending this way.

After a miscarriage, there can be some tissue and/or blood clot left in the uterus (womb). This tissue and/or blood clot may pass naturally or we can perform an operation to remove this or you can also have medication to empty the womb.

The procedure is performed under a general anaesthetic (this will be explained further later in this leaflet). Generally you will be admitted onto the Day Surgery Unit for this at a planned time and date (Elective admission). Occasionally it is necessary for you to have this done sooner and you may stay on the Early Pregnancy Unit (on Daphne ward) or be admitted onto the in-patient Gynaecology Ward.

## Intended benefits

- To remove any remaining tissue and blood clot in the uterus (womb) after a miscarriage. Many women find surgery a benefit as the miscarriage can be "over and done with" and they can plan around this. (Miscarriage Association 2010)
- In addition the doctor will suggest this procedure for the following clinical indications as opposed to the alternative methods for managing miscarriage:
  - to treat sepsis (infection)
  - to alleviate heavy bleeding
  - to ensure completion of miscarriage if suspicion of gestational trophoblastic disease (a rare and serious condition of early pregnancy).

## Who will perform my procedure?

This procedure will be performed or supervised by a consultant gynaecologist.

## Before your procedure

Most patients are seen on the Early Pregnancy Unit, when you will meet one of the nurses and/or a doctor. At this time, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring any packaging with you.

This procedure involves the use of general anaesthesia. We explain about the different types of anaesthesia or sedation we may use at the end of this leaflet. You will see an anaesthetist before your procedure.

You must not eat anything for at least six hours prior to your procedure after which you are allowed to drink water only until three hours prior to your procedure. The

staff will advise you at what time to do this.

This procedure is a day case procedure and most women are able to go home a few hours after the operation. Sometimes we can predict whether you will need to stay longer than usual – your doctor/nurse will discuss this with you before you decide to have the procedure.

Sometimes you may be given medication called misoprostol to help the opening up of the cervix, if this has not already happened. Generally this is given as a vaginal pessary an hour before your operation.

### **What do I need to bring in with me?**

- Basic toiletries, such as a toothbrush and some sanitary towels.
- A dressing gown and some slippers.
- Wear only a minimal amount of jewellery. Only small rings, which will be taped, are allowed into the theatre suite.
- Do not wear makeup, and ensure any nail polish is removed from your finger and toe nails.
- If you wear contact lenses, they will need to be removed prior to your going into theatre.

### **May I bring someone with me?**

Yes. Your partner, friend or family member is welcome to stay with you for the day. However, there are **no** facilities to care for children on the unit, therefore please make your own arrangements for childcare before attending the hospital.

### **During the procedure**

Once you are asleep with the general anaesthetic, the gynaecologist inserts a speculum into your vagina so that the cervix (the opening of the uterus) can be seen. We then gently stretch open the cervix using some dilators, and pass a hollow tube through it. We then use some suction to remove the retained tissue and any blood clot. After emptying the womb by suction, the womb is usually explored with other instruments which can remove any tissue that may remain or confirm the womb is empty. These instruments include one called a curette which many women have heard about as it is often described as having a scrape. The procedure takes less than 15 minutes.

### **After the procedure**

Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure, oxygen levels and any vaginal bleeding you may have. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward.

**If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after major surgery.**



**Eating and drinking.** After this procedure, you should not have anything to eat or drink until your medical team considers it to be safe - this is usually as soon as you are awake enough. We also recommend you avoid any alcohol for the first 24 hours following the procedure as any effects will be enhanced by the anaesthetic.



**Getting about after the procedure.** We will help you to become mobile as soon as possible after the procedure. This helps improve your recovery and reduces the risk of certain complications. If you have any mobility problems, we can arrange nursing or physiotherapy help.



**Leaving hospital.** Generally most people who have had this operation will be able to go home a minimum of four hours after the operation, on the same day. The actual time that you stay in hospital will depend on your general health, how quickly you recover from the procedure and your doctor's opinion. You must have had something to eat and drink, been able to pass urine, have minimal pain and vaginal bleeding and have someone to take you home and be with you overnight.



**Resuming normal activities including work.** Most women prefer to take the following day off work, both for their emotional and physical recovery. You must not drive for 24 hours following general anaesthetic as the drugs may still be in your system. If you have another child at home we suggest you have another adult around to assist you as you may be sleepy. Some women can take up to a week off work - you are able to self-certificate for up to five working days.

**Emotional impact:** Women react in different ways to a miscarriage: some women come to terms with what has happened within a few weeks, others can take much longer. It is normal to feel tearful and sad, angry or even guilty. Losing a baby can be a very painful experience for partners too, and sometimes their grief is unacknowledged.



**Special measures after the procedure:** If your blood group is rhesus negative, we will give you an injection of anti-D immunoglobulin. This will help prevent antibodies forming and affecting later pregnancies.

- **Vaginal bleeding:** You may have some vaginal bleeding for one to two weeks following the procedure; we advise you to use sanitary towels and not tampons, and to avoid sexual intercourse or swimming until the bleeding has stopped. This is to help prevent any infection. The bleeding is like a heavy period for the first day or so but this will lessen over time and you may even have a brown discharge before it stops completely. We also suggest that you avoid long soaks in the bath and use a shower instead, and ensure someone is around when you do this in case the hot

water makes you feel faint/dizzy. Should you have concerns that your bleeding is not settling or you have a fever and 'flu-like' symptoms then contact your GP (General Practitioner) or contact us on the numbers below.

- **Next period:** Your next period may happen in four to six weeks after the procedure
- **Pain:** You may have period-like pains for a few days, this is normal. Simple painkillers that you can buy over the counter such as paracetamol and ibuprofen should help this.

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**Check-ups and results:** Unless you are otherwise told, you will not be contacted specifically by the Early Pregnancy Unit (EPU) following your operation. However, if you have any concerns or questions you can telephone them directly.

- If this is not your first miscarriage and you meet certain criteria you may be referred to the recurrent miscarriage clinic. This may involve you having additional tests before this appointment. The staff on the Early Pregnancy Unit will discuss this with you.
- **Do I need to inform anyone about my miscarriage?** No. Staff on Daphne ward will have written to your GP and community midwife and any antenatal scans or appointments will have been cancelled, so you do not need to worry about doing this.
- **Future pregnancies:** It is possible to conceive a few weeks after your operation therefore you may wish to consider some form of contraception. We advise you to contact your GP or local family planning clinic for further advice. You are able to try for another pregnancy whenever you feel ready; there are no rules as to when you can do this. If you have any concerns about this then please speak to a member of staff.

## Significant, unavoidable or frequently occurring risks of this procedure

If you have a pre-existing medical condition, are obese or have had previous surgery the quoted risks for serious or frequent complications will be increased.

The table below is designed to help you understand the risks associated with this type of surgery (based on the RCOG Clinical Governance Advice, Presenting Information on Risk).

Term	Equivalent numerical ratio	Colloquial equivalent
Very common	1/1 to 1/10	A person in family
Common	1/10 to 1/100	A person in street
Uncommon	1/100 to 1/1000	A person in village
Rare	1/1000 to 1/10 000	A person in small town
Very rare	Less than 1/10 000	A person in large town

- Surgical management of miscarriage is a very safe operation, however, like all surgical procedures there are potential risks involved. Your gynaecologist and

nurse will ensure that the appropriate measures are taken to reduce the risk of complications. The main risks of the procedure are:

### Serious risks

- Tear in the cervix. (Rare).
- Uterine perforation; this means a hole is made in the uterus. (Uncommon – up to 5 in 1000 women). This is a risk because the wall of the recently pregnant womb is very soft. This can cause trauma to other abdominal organs. If this happens it might be necessary to check that there is no internal bleeding using a laparoscopy. This is a procedure in which a laparoscope (telescope) is passed through a small cut below the navel. If there is internal bleeding, we might be able to control this using this 'key hole' surgery or you might need a larger 'open operation', which will take longer to recover from.
- Deep vein thrombosis (blood clot in the leg).
- Death (very rare – 0.5 in every 100 000).

### Frequent risks

- Bleeding that lasts for up to two weeks is very common but blood transfusion is uncommon (1-2 in 1000 women)
- Infection of the lining of the womb. (Common – 3 in 100 women)
- Intrauterine adhesions (stickiness inside the womb) (Uncommon – 1 in every 200 women)
- There is a rare chance that we will miss some of the retained tissue and that you will require a further operation to remove it. (Common - up to 5 in 100 women).

### Alternative procedures that are available

Surgical management of miscarriage is not recommended if your pregnancy is less than seven weeks gestation due to the increased risks involved at this stage. We would therefore recommend you undertake one of the following two pathways listed below.

At any stage whether your pregnancy was less than seven weeks or greater than seven weeks you may also undertake one of the following pathways. Staff on the ward will explain these to you in more detail.

- If the bleeding is not excessive, and you prefer not to have an operation, you might wish to wait and allow the womb to expel the remaining tissue without assistance (**expectant management**).
- You might choose to have **medical management**, when you will be given some tablets to cause the womb to contract and empty itself. The success rate of a medical evacuation in emptying the uterus can, in some cases, be slightly less than the surgical approach although this is to be balanced against the risks of surgery.

## What happens to any tissue or the fetus?

Any tissue or fetal parts removed during the operation are sent to the histopathology laboratory to confirm the miscarriage.

No other investigations are usually carried out into the cause of the miscarriage at this time unless specifically discussed with you.

## Further arrangements

There are standard procedures in place for the disposal of fetal remains following miscarriages which are described briefly below. If you wish to obtain more detailed information of the processes, please contact one of the people named at the end of this document:

- Fetal remains below 13 weeks gestation are cremated within the hospital, in accordance with the relevant code of practice. This is planned and organised to ensure that no other material is dealt with at the same time. The process is witnessed by two members of the bereavement team.
- Fetal remains above 13 weeks gestation are cremated at the local crematorium in a monthly group service taken by the lead Chaplain for the Trust. In order to maintain patient confidentiality the patient's name is not used to identify the remains.
- A woman or couple may decide to make arrangements themselves, either at home or in a local cemetery/crematorium using a funeral director. To arrange this please contact one of the people listed below, prior to the procedure.

If you wish to discuss any of the above, or to have further information, please contact Daphne Ward staff (01223 217636) or one of the Chaplaincy team (01223 217769).

## What if I think I have miscarried before I come in for the operation?

This does sometimes happen, so it is advisable to have some sanitary towels and mild analgesia (pain relief) such as paracetamol or ibuprofen at home, just in case.

The bleeding may be very heavy, and you may pass blood clots, tissue or even a recognisable fetus.

If you are concerned that the bleeding is excessive (requiring you to change a sanitary pad every half an hour) please telephone us on the numbers listed later in this information leaflet.

**We understand that bleeding heavily at home can be frightening - please do not hesitate to contact us if you are unsure what to do.**

If you think you have miscarried, an operation may not be necessary, provided you are well and the bleeding has lessened. We would still like for you to attend so that staff can discuss this with you and together you can make an informed decision.

If clinically indicated it may be possible to arrange an ultrasound prior to the procedure. However, generally at this time it is **not** beneficial, as it would normally show blood in the womb anyway.

Please telephone Daphne ward to discuss the situation with nursing staff.

**If you miscarry over the weekend, but are well, please telephone Daphne ward** before 08:30 on Monday morning **or** attend the day surgery unit as planned and discuss the situation with medical staff.



### Information and support

You might be given some additional patient information before or after the procedure, for example: leaflets that explain what to do after the procedure and what problems to look out for.

If you have any questions or anxieties, please feel free to ask a member of staff including staff on:

- The Early Pregnancy Unit, Daphne Ward  
01223 217636  
Open 08:00 – 20:00 Monday to Friday and 08:30 – 14:00 at weekends  
Closed Bank holidays
- Inpatient Gynaecology ward  
01223 348544  
At all other times

#### Other useful sources of support:

- The Miscarriage Association  
01924 200799 (Monday-Friday 09:00 – 16:00)  
[www.miscarriageassociation.org.uk](http://www.miscarriageassociation.org.uk)

- The Royal College of Obstetricians and Gynaecologists  
Recovering Well Patient Information  
[www.rcog.org.uk](http://www.rcog.org.uk)

[Information about recovering from surgical management of a miscarriage \(pdf\)](#)

## Anaesthesia

Anaesthesia means 'loss of sensation'. There are three types of anaesthesia: general, regional and local. **The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness.**

Sometimes different types of anaesthesia are used together.

### **Before your operation**

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

### **Pre-medication**

You may be prescribed a 'premed' prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have. *Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.*

### **Moving to the operating room or theatre**

You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.**

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

### **General anaesthesia**

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all

times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.

### **Regional anaesthesia**

Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.

### **Local anaesthesia**

In local anaesthesia the local anaesthetic drug is injected into the skin and tissues at the site of the operation. The area of numbness will be restricted. Some sensation of pressure may be present, but there should be no pain. Local anaesthesia is used for minor operations such as stitching a cut, but may also be injected around the surgical site to help with pain relief. Usually a local anaesthetic will be given by the doctor doing the operation.

### **Sedation**

Sedation is the use of small amounts of anaesthetic or similar drugs to produce a 'sleepy-like' state. Sedation may be used as well as a local or regional anaesthetic. The anaesthesia prevents you from feeling pain and the sedation makes you drowsy. Sedation also makes you physically and mentally relaxed during an investigation or procedure which may be unpleasant or painful (such as an endoscopy) but where your co-operation is needed. You may remember a little about what happened but often you will remember nothing. Sedation may be used by other professionals as well as anaesthetists.

### **What will I feel like afterwards?**

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

### **What are the risks of anaesthesia?**

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

#### **Very common (1 in 10 people) and common side effects (1 in 100 people)**

- Feeling sick and vomiting after surgery
- Sore throat
- Dizziness, blurred vision
- Headache
- Bladder problems
- Damage to lips or tongue (usually minor)
- Itching
- Aches, pains and backache
- Pain during injection of drugs
- Bruising and soreness
- Confusion or memory loss

#### **Uncommon side effects and complications (1 in 1000 people)**

- Chest infection
- Muscle pains
- Slow breathing (depressed respiration)
- Damage to teeth
- An existing medical condition getting worse
- Awareness (becoming conscious during your operation)

#### **Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications**

- Damage to the eyes
- Heart attack or stroke
- Serious allergy to drugs
- Nerve damage
- Death
- Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK.

For more information about anaesthesia, please visit the Royal College of Anaesthetists' website: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)

## Information about important questions on the consent form

### 1 Creutzfeldt Jakob Disease ('CJD')

We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

### 2 Photography, Audio or Visual Recordings

As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

### 3 Students in training

Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

### 4 Use of Tissue

As a leading bio-medical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet '*Donating tissue or cells for research*' gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on **01223 216756**.



## Privacy & dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.



We are currently working towards a smoke free site. Smoking is only permitted in the designated smoking areas. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169



## Help with this leaflet

If you would like this information in large print, another language or in audio format, please ask the department to contact Patient Information on 01223 216032 or [patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)



## Document history

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# Consent Form

## Surgical management of miscarriage

**A** Patient's side left / right or N/A

For staff use only:

Hospital number:

Surname:

First names:

Date of birth:

NHS no: \_ \_ \_ / \_ \_ \_ / \_ \_ \_

Use hospital identification label

### Consultant or other responsible health professional

Name and job title: .....

Any special needs of the patient (e.g. help with communication)? .....

Please use 'Procedure completed' stamp here on completion:

### B Statement of health professional (details of treatment, risks and benefits)

I confirm I am a health professional with an **appropriate knowledge of the proposed procedure**, as specified in the hospital's consent policy. I have explained the procedure to the patient. In particular, I have explained:

a) the intended benefits of the procedure (please state)

- To remove any remaining tissue and blood clot in the uterus (womb) after a miscarriage. Many women find surgery a benefit as the miscarriage can be "over and done with" and they can plan around this. (Miscarriage Association 2010)
- to treat sepsis (infection)
- to alleviate heavy bleeding
- to ensure completion of miscarriage if suspicion of gestational trophoblastic disease (a rare and serious condition of early pregnancy).

b) the possible risks involved. Addenbrooke's always ensures any risks are minimised. However all procedures carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient

**Serious risks:** Tear in the cervix. (Rare); Uterine perforation - If this happens it might be necessary to check that there is no internal bleeding using a laparoscopy. If there is internal bleeding, we might be able to control this using this 'key hole' surgery or you might need a larger 'open operation', which will take longer to recover from; Deep-vein thrombosis (blood clot in the leg); Death (very rare - 0.5 in every 100 000).

**Frequent risks:** Bleeding that lasts for up to two weeks is very common but blood transfusion is uncommon; Infection of the lining of the womb; Intrauterine adhesions (stickiness inside the womb); There is a rare chance that we will miss some of the retained tissue and that you will require a further operation to remove it.

c) what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:

# Consent Form

## Surgical management of miscarriage

For staff use only:

Hospital number:

Surname:

First names:

Date of birth:

NHS no: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Use hospital identification label

d) any extra procedures that might become necessary during the procedure such as:

Blood transfusion

Other procedure (please state)

The following information leaflet has been provided:

Surgical management of miscarriage

CF463, version 1 January 2013

Version, reference and date:

or  I have offered the patient information about the procedure but this has been declined.

3 This procedure will involve:

General and/or regional anaesthesia

Local anaesthesia

Sedation

None

Signed (Health professional): ..... Date: R.R./M.M./Y.Y.X.Y.

Name (PRINT): ..... Time (24hr): .....:.....

Designation: ..... Contact/bleep no: .....

### C Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

**Important:** please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

#### 1 Creutzfeldt Jakob disease (CJD)

Have you ever been notified that you are at risk of CJD or variant CJD

for public health purposes? If yes, please inform your health professional.  Yes  No

#### 2 Photography, Audio or Visual Recording

a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.  Yes  No

b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.  Yes  No

#### 3 Medical Training

I agree to the involvement of trainee medical and other students as part of their formal training.  Yes  No

# Consent Form

## Surgical management of miscarriage

For staff use only:  
Hospital number:  
Surname:  
First names:  
Date of birth:  
NHS no: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Use hospital identification label

### 4 Use of Tissue

- a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research.  Yes  No
- b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records.  Yes  No

I have listed below any procedures that I do not wish to be carried out without further discussion.

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): ..... Date: .....

Name of patient (PRINT): .....

*If signing for a child or young person; delete if not applicable.*

I confirm I am a person with parental responsibility for the patient named on this form.

Signed: ..... Date: .....

Relationship to patient: .....

*If the patient is unable to sign but has indicated his/her consent, a witness should sign below.*

Signed (Witness): ..... Date: .....

Name of witness (PRINT): .....

Address: .....

# Consent Form

## Surgical management of miscarriage

For staff use only:

Hospital number:

Surname:

First names:

Date of birth:

NHS no: \_\_\_ / \_\_\_ / \_\_\_

Use hospital identification label

### D Confirmation of consent

**Confirmation of consent** (where the treatment/procedure has been discussed in advance)  
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): ..... Date: .....  
.....

Name (PRINT): ..... Job title: .....

Please initial to confirm all sections have been completed: .....

### E Interpreter's statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): ..... Date: .....

Name (PRINT): .....

Or, please note the language line reference ID number: .....

### F Withdrawal of patient consent

The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): ..... Date: .....

Signed (Health professional): ..... Date: .....

Name (PRINT): ..... Job title: .....

# Patient agreement to investigation or treatment

## Surgical termination of pregnancy (7-13 weeks gestation)

**Authors:** Gynaecological Department

**Brief description:**

- The purpose of this treatment is to surgically remove your pregnancy. The operation will be performed under general anaesthetic and you should expect to be in hospital for to the majority of the day for treatment.
- Here, we explain some of the aims, benefits, risks and alternatives to this procedure (operation). We want you to be informed about your choices to help you to be fully involved in making any decisions.
- Please ask about anything you do not fully understand or wish to have explained in more detail.
- If you would like this information in another format or language or would like help completing the form, please ask a member of our staff.

**Please bring this form with you to hospital**

- You will be asked to read this form carefully, and you and your doctor (or other appropriate healthcare professional) will sign it to document your consent.
- All our consent forms are available on the Addenbrooke's website:  
<http://www.cuh.org.uk/consent>
- Remember, you can change your mind about having the procedure at any time.

---

**For staff use:**

Does the patient have any special requirements? (For example, requires an interpreter or other additional communication method)

.....  
.....

## About Surgical termination of pregnancy

Surgical termination of pregnancy is an operation that is performed under a general anesthetic in the Day Surgery Unit located in the Addenbrookes Treatment Centre. You will be asked to come to the Unit having had nothing to eat or drink (the timing of this will have been given to you in clinic) at a pre-arranged date and time. During the operation your pregnancy will be removed by gentle suction whilst you are asleep. Generally women who have this done are with us for the morning or afternoon depending on the timing of the operation. You will need someone to collect you and to be with you overnight.

## Before your procedure

- You will have been seen at the termination referral (TR) clinic, where you will meet nurses and doctors who are specialists in reproductive health.
- At this clinic, we shall ask you for details of your medical history and carry out any necessary clinical examinations and investigations. This is a good opportunity for you to ask us any questions about the procedure, but please feel free to discuss any concerns you might have at any time.
- You will be asked if you are taking any tablets or other types of medication - these might be ones prescribed by a doctor or bought over the counter in a pharmacy. It helps us if you bring details with you of anything you are taking. (for example: bring the packaging with you).
- This procedure involves the use of general anaesthesia. See below for further details about the types of anaesthesia we shall use.
- Most people who have this operation will have it done as a day-case procedure.

## What do I need to bring in with me?

- Bring some basic toiletries with you, such as a toothbrush and some sanitary towels.
- Bring a dressing gown and some slippers.
- Wear only a minimal amount of jewellery. Only small rings, which will be taped, are allowed into the theatre suite.
- Do not wear makeup, and ensure any nail polish is removed from your finger and toe nails.
- If you wear contact lenses, they will need to be removed prior to your going into theatre.

## May I bring someone with me?

Yes. Your partner, friend or family member is welcome to stay with you for the day. However, there are no facilities to care for children on the unit, therefore please make your own arrangements for childcare before attending the hospital.

## During treatment

- Depending upon the gestation (number of completed weeks) of your pregnancy and your previous obstetric history (the story of any previous pregnancies you have had), you may be given a vaginal pessary (a tablet placed into your vagina close to the cervix [opening of the womb]) to help the cervix to open easier during the procedure.

The aim of this is to reduce any risks related to this operation and any future pregnancies you may have. This will be done before you have your anaesthetic and is not painful. We ask at this point that you stay on the bed and not walk around in case the pessary falls out. Should you need to get up for any reason – such as to go to the toilet, please ask the nursing staff for help.

- Before your procedure, you will be given the necessary anaesthetic - see below for details of this and the role of the anaesthetist in your care
- When you are asleep, first the neck of the womb (cervix) is stretched, and then a soft plastic tube is inserted into the womb (uterus) and the contents are removed by suction (this does not involve the cutting of any tissue).
- While you are still under anaesthetic, an antibiotic called Metronidazole (Flagyl) will be given to you rectally (into your back passage). It is absorbed into your blood stream and helps to reduce the risk of later infection in your womb. It has fewer side-effects when given rectally than when it is taken by mouth. If you know you are allergic to this antibiotic, or if for any other reason you do not wish to have this treatment, you should tell the clinic doctor.

## After treatment

- After your operation, you will wake up in the recovery room. You might have an oxygen mask on your face to help you breathe. You might also wake up feeling sleepy.
- After this procedure, most people will have a small, plastic tube in one of the veins of their arm. This might be attached to a bag of fluid (called a drip), which feeds your body with fluid until you are well enough to eat and drink by yourself.
- While you are in the recovery room, a nurse will check your pulse, blood pressure and vaginal loss (any bleeding from the vagina) regularly. When you are well enough to be moved, you will be taken to a ward.
- Sometimes, people feel sick after an operation and might vomit. The nurse can give you medicine to stop the sickness/vomiting.
- **Eating and drinking:** After this procedure, you should not have anything to eat or drink until your medical team considers it to be safe - this is usually as soon as you are awake enough
- **Getting around and about:** After this procedure, we will try to get you mobile (up and about) as soon as we can to help prevent complications from lying in bed. Typically, you will be able to get up after one hour.
- **When you can leave hospital:** Most women are able to go home a minimum of four hours after the operation, on the same day. The actual time that you stay in hospital will depend on your general health, how quickly you recover from the procedure and your doctor's opinion.

You must have had something to eat and drink, been able to pass urine, have minimal pain and vaginal bleeding and have someone to take you home and be with you overnight.

- **When you can resume normal activities including work:** Plan to take it easy at home the day after your operation, although you will probably feel well enough to go to work the day after that. You are able to self-certify for up to five days.
- For 24 hours following general anaesthetic you **must not:**
  - drive a car or any other vehicle or cycle
  - operate any apparatus or machinery – including a cooker
  - do any strenuous exercise
  - drink any alcohol

### Special measures you need to take after the procedure:

- **Bleeding:** You will have some bleeding for up to ten days following this procedure. The bleeding should gradually become less. You should use sanitary pads, not tampons, during this time to reduce the risk of infection, so make sure you have some at home. Should the bleeding last longer than two weeks, become heavier, or smell offensive then please either contact us on the numbers below or see your General Practitioner (GP) as this may be a sign of an infection. If you are changing your sanitary towels more than every half an hour then contact us as soon as possible.
- **Next period:** Your next period may happen in four to six weeks after the procedure
- **Pain:** At first you may have some pain (like period pains) these may last for a few days – again make sure you have some paracetamol or similar pain killers at home. If the pain is not settling and becoming distressing then contact us or see your GP
- **Hygiene:** As previously mentioned please use sanitary towels and do not use tampons. You are able to shower following the procedure but do not have the water temperature too hot as this may make you feel faint and dizzy. It may be advisable to ensure there is a responsible adult in the house when you do this.
- **Anti-D:** Women whose blood group is rhesus negative will be given an injection of anti-D before leaving to protect future pregnancies from being affected by rhesus incompatibility.
- **Resuming sexual relations:** Because of the risk of infection you are advised not to have sexual intercourse until several days after the bleeding has stopped. If you do have intercourse during this time, it is advisable to use a condom to reduce the risk of infection, even if you are using another method of contraception.
- **Contraception:** Following a termination of pregnancy many women are worried that if their method of contraception has let them down once then it might happen again. Others decide this is an appropriate time to change their method. A preliminary discussion about future contraception will have taken place at the Termination referral (TR) Clinic.

A new pregnancy can be conceived very soon after a termination and you should start your chosen method of contraception straight away.

- The injection method (Depo-Provera) or Intra Uterine Contraceptive Device (IUD - coil) or Nexplanon (progesterone implant) can be organised for you whilst you are under anaesthetic if you have discussed this with the doctor at the Termination Referral (TR) clinic visit and it has been prescribed for you. Alternatively it can be given at your GP surgery or at the Family Planning Clinic when you make a follow up appointment two to three weeks after the operation. However, in the mean time you must use another form of contraception.
- If you have decided to take the oral contraceptive pill, you should start it on the same day you leave the hospital.

### **How will I feel emotionally?**

It is not unusual to feel low after having a termination, although for most women the overwhelming feeling is one of relief. If you continue to feel low, and talking with friends does not seem to help, then please do contact your GP.

### **Swabs**

Swabs are taken from your vagina at the TR clinic to check for infection. Usually the results will have been available at the time of your operation and you will have been given antibiotics if necessary. If you were found to have an infection called chlamydia you will also have been advised that your sexual partner needs to be investigated and, if necessary, treated. You will have been given information about the genito-urinary medicine clinic at Addenbrooke's Hospital, Clinic 1A. If your partner is not treated then he may re-infect you with chlamydia.

Occasionally the swab results are not back from the laboratory by the time you have your operation. In this situation we will have given you antibiotics 'just in case'. If, when we later get the results, we find you had a chlamydia infection we will write to you about getting treatment for your sexual partner.

### **Intended benefits of the procedure**

The benefit of a surgical termination is that you only have one visit to the hospital for the termination itself after the clinic appointment. Some women feel that surgery "gets it over and done with whilst they are asleep and it can be a less painful procedure".

You will not have to see the fetus or any tissue as the procedure takes place whilst you are asleep.

### **Who will perform my procedure?**

This procedure will be performed or supervised by a Consultant Gynaecologist.

## Alternative procedures that are available

- Any alternative procedures to surgical termination depend on the stage of your pregnancy. These options will be discussed with you in detail at the clinic. Generally the alternative is a medical termination during which you will be given tablets to induce a miscarriage
- If your pregnancy is more than 13 weeks gestation (number of completed weeks of pregnancy) you will not be eligible for a surgical termination and you will be advised to have a medical termination of pregnancy.
- You could choose to keep the pregnancy

## Serious or frequently occurring risks

If you have a pre-existing medical condition, are obese, have significant pathology or have had previous surgery the quoted risks for serious or frequent complications will be increased.

The table below is designed to help you understand the risks associated with this type of surgery (based on the RCOG Clinical Governance Advice, Presenting Information on Risk).

Term	Equivalent numerical ratio	Colloquial equivalent
Very common	1/1 to 1/10	A person in family
Common	1/10 to 1/100	A person in street
Uncommon	1/100 to 1/1000	A person in village
Rare	1/1000 to 1/10 000	A person in small town
Very rare	Less than 1/10 000	A person in large town

It is reassuring to know that this operation is very safe. However, no procedure is absolutely safe, and it is important that you know what the risks are.

## Serious risks

- Injury to the cervix or uterus (womb) at the time of operation may occur in one in 200 cases (Uncommon). In the majority of these, the injury heals itself. If it is thought such an injury may have occurred at the time of your operation, the surgeon may go on to perform a laparoscopic examination - looking into the abdomen (tummy) through a laparoscope (telescope) to check whether any damage has occurred which requires further intervention. If further treatment is necessary you may have to be admitted to hospital overnight. As mentioned previously to reduce the risk of injury to the cervix (opening of the womb) some women are given vaginal tablets, which start to soften the cervix, before the operation. The need for these depends on your age and the duration of the pregnancy. The tablets are put into your vagina, by a nurse or doctor, one to two hours before the operation.
- **Bleeding** that requires blood transfusion can occur in about one in 500 women (Uncommon). We take blood at your clinic visit and this is held by the laboratory in case you need to have blood urgently cross matched.

- **Blood clots** in the veins can occur after most surgical operations, but this is unusual after early terminations.
- **Death** Overall, the risk to your life of a surgical termination of pregnancy in the first 12 weeks is very low at about one in 100,000 (Very rare). The risks to life of a full term pregnancy are about eight times higher than the risks of an early termination.
- **Failure to terminate the pregnancy** may occur. This is more likely before seven weeks of pregnancy, which is why the operation is not normally done before this time. However, it can rarely happen at later dates and so it is important that you consult your GP or Family Planning Clinic for a checkup if you continue to feel pregnant.

You should expect to have a period about four weeks after the operation. (Pregnancy tests may continue to show positive for several days after a successful termination).

### Frequent risks

- **Infection** can occur in about one in 20 women (Common). If it is left untreated it may make it difficult to get pregnant at a later date. If you experience an increase in bleeding, lower abdominal pain, a raised body temperature or a smelly vaginal discharge after your operation you should see your GP immediately so that you can be started on antibiotics. Occasionally, women have to be readmitted to hospital for an infection to be treated more intensively.
- **Retained products:** Occasionally there may be some tissue left behind – Uncommon 5 in every 100 women

### Disposal of fetal tissue

#### Arrangements for disposal of the fetal remains:

There are standard procedures in place for the disposal of fetal remains which are described briefly below. If you wish to obtain more detailed information of the processes, please contact one of the people named at the end of this document:

- Fetal remains below 13 weeks gestation are cremated within the hospital, in accordance with the relevant code of practice. This is planned and organised to ensure that no other material is dealt with at the same time. The process is witnessed by two members of the bereavement team.
- A woman or couple may decide to make arrangements themselves, either at home or in a local cemetery/crematorium using a funeral director. To arrange this please contact one of the people listed below, prior to the procedure.

If you wish to discuss any of the above, or to have further information, please contact Daphne Ward staff (ext. 3636), one of the Chaplaincy team (ext. 3769), or the Bereavement Coordinator (ext. 3619).

## Information and support

- You might be given some additional patient information before or after the procedure, for example: leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please feel free to ask a member of staff including:
- The Early Pregnancy Unit, Daphne Ward  
01223 217636  
Open 08:00 – 20:00 Monday to Friday and 08:30 – 14:00 at weekends  
Closed Bank holidays
- Day Surgery Unit  
01223 216288  
Open 08.00 – 17.00 Monday to Friday
- Inpatient Gynaecology ward  
01223 348544  
At all other times

## General anaesthesia

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

## Before your operation

Before your operation your anaesthetist will visit you in the ward, although occasionally this will happen in a pre-anaesthetic assessment clinic. If you are a day case patient it may not be until just before your operation. The anaesthetist who looks after you on the day of your operation is the one who is responsible for making the final decisions about your anaesthetic. He or she will need to understand about your general health, any medication that you are taking and any past health problems that you have had. Your anaesthetist will want to know whether or not you are a smoker, whether you have had any abnormal reactions to any of the drugs or if you have any allergies. They will also want to know about your teeth, whether you wear dentures, have caps or a plate. Your anaesthetist needs to know all these things so that he or she can assess how to look after you in this vital period. Your anaesthetist may examine your heart and lungs and may also prescribe medication that you will be given shortly before your operation, the pre-medication or 'pre-med'.

**Pre-medication** is the name given to medication (drugs) given to you some hours before your operation. These drugs may be given as tablets, injections or liquids. They relax you and may send you to sleep. They are not always given.

Do not worry if you do not have a pre-med, your anaesthetist has to take many factors into account in making this decision and will take account of your views on the topic if possible. Do not be worried about your anaesthetic.

When your anaesthetist visits you before your operation, this is the time to ask all the questions that you may have, so that you can forget your fears and worries.

Before your operation you will usually be changed into a gown and wheeled to the operating suite into an anaesthetic room. This is an ante-room outside the theatre. The anaesthetist, his or her assistant and nurses are likely to be present. An intravenous line (drip) may be inserted. Monitoring devices may be attached to you, such as a blood pressure cuff or a pulse oximeter. A pulse oximeter is usually a little red light in a small box, which is taped to your finger. It shows how much oxygen you have in your blood and is one of the vital monitors that an anaesthetist uses during your operation to ensure that you remain in the best of health. You may be given some oxygen to breathe.

### **During your operation**

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you in the correct level of unconsciousness for the period of the surgery. Your anaesthetist is constantly aware of your condition and trained to respond. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement. If you have any other medical conditions, your anaesthetist will know of these from your pre-operative assessment and be able to treat them during surgery.

### **After your operation**

After your operation your anaesthetist continues to monitor your condition carefully. You will probably be transferred to a recovery ward where specially trained nurses, under the direction of anaesthetists, will look after you. Your anaesthetist and the recovery nurses will ensure that all the anaesthetic effects are reversed and that you are closely monitored as you return to full consciousness. You may be given some oxygen to breathe in the recovery area, and may find that intravenous drips have been inserted whilst you are unconscious in theatre and that these will be replacing fluids that you might require. You will be given medication for any pain that you might feel, and systems, such as Patient Controlled Analgesia (PCA) may be set up to continue pain control on the ward.

You are likely to feel drowsy and sleepy at this stage. Some patients feel sick, others may have a sore throat related to the insertion of the breathing tube during surgery. During this time it is important that you relax as much as you can, breathe deeply, do not be afraid to cough, and do not hesitate to ask the nursing staff for any pain relief, and about any queries you may have. You are likely to have hazy memories of this time and some patients experience vivid dreams. Once you are fully awake you will be returned to the ward, and if you are a day patient will be allowed to go to the waiting area to fully recover before you are accompanied home. Do not expect to feel completely normal immediately!

## What are the risks of general anaesthesia?

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on; whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or done in an emergency. Please discuss any pre-existing medical condition with your anaesthetist.

- Very common and common side effects (1 in 10 or 1 in 100 people)  
Feeling sick and vomiting after surgery, sore throat, dizziness, blurred vision, headache, itching, aches, pains and backache, pain during injection of drugs, bruising and soreness, confusion or memory loss.
- Uncommon side effects and complications (1 in 1000 people) Chest infection, bladder problems, muscle pains, slow breathing (depressed respiration), damage to teeth, lips or tongue, an existing medical condition getting worse, awareness (becoming conscious during your operation).
- Rare or very rare complications (1 in 10,000 or 1 in 100,000)  
Damage to the eyes, serious allergy to drugs, nerve damage, death, equipment failure.

## Day case anaesthesia

Many operations these days are carried out as day cases. This means you will come into hospital on the day of the operation, often only a short time before it is due to start. Sometimes you will be seen preoperatively for assessment, which is important because some people are not fit enough for day care. You will usually be seen by your anaesthetist on the admission day, in the day care ward.

Take all your normal drugs on the day of operation (unless they are diabetic drugs - do not take them): it is safe to take a sip of water to wash tablets down. The hospital will tell you when to stop eating and drinking before the operation: be sure to follow those instructions, or your operation may be cancelled

It is not usual to have a premed for day care operations, as these can slow recovery.

Most day case operations are more minor, and usually do not require major pain killers afterwards. However, you may need tablets, and it is important that you have some sort of pain killers at home. If you have not, the hospital may give you a supply to take with you.

Sometimes patients do have quite a bit of pain after day case operations, and may feel sick. Do not expect to feel normal straight away, and do not plan anything important for the evening after your day case operation. Occasionally the pain or sickness is severe enough for you to be kept in hospital, though that is unusual.



We are currently working towards a smoke free site. Smoking is only permitted in the designated smoking areas.

For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169

**Help with this leaflet:**



If you would like this information in another language, large print or audio format, please ask the department to contact Patient Information: 01223 216032 or

[patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)



**Document history**

Authors	Gynaecology Department
Department	Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ <a href="http://www.cuh.org.uk">www.cuh.org.uk</a>
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Version number/Ref	4/CF235

# Patient agreement to investigation or treatment

<b>For staff use only:</b>	
Surname:	
First names:	
Date of birth:	
Hospital no:	
Male/Female:	
(Use hospital identification label)	

Responsible health professional/job title

Special requirements .....  
(For example, other language/other communication method)

**Name of proposed procedure or course of treatment**

## Surgical termination of pregnancy (7 – 13 weeks gestation)

**Statement of health professional**

(To be filled in by a health professional with an appropriate knowledge of the proposed procedure, as specified in the Hospital's consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended aim of the procedure: As documented in the attached leaflet

- Any serious or frequently occurring risks from the procedures including those specific to the patient: As documented in the attached leaflet

- Any extra procedures that might become necessary during the procedure

Blood transfusion     Other procedure (please specify) As documented in the attached leaflet

I have discussed what the treatment / procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

- The following information leaflet has been provided: Surgical termination of pregnancy.

..... Version/Date/Ref: 4/January 2012/CF235 .....

This procedure will involve:

- General and/or regional anaesthesia     Local anaesthesia     Sedation

Health professional's signature: ..... Date: .....

Name (PRINT): ..... Job title: .....

Contact details (if patient wishes to discuss details later)

I have offered the patient information about the procedure but s/he has declined information.

**Statement of the interpreter (if appropriate)**

I have interpreted the information to the best of my ability, and in a way in which I believe s/he can understand:

Interpreter's signature ..... Date: .....

Name (PRINT): .....

**Important notes: (tick if applicable)**

- The patient has withdrawn consent (ask patient to sign/date here) .....
- See also advance directive/living will (eg Jehovah's Witness form)

Copy accepted by patient: yes / no (please circle)

**For staff use only:**

**Surname:** .....

**First names:** .....

**Date of birth:** .....

**Hospital no:** .....

**Male/Female:** .....

**(Use hospital identification label)**

**Statement of patient**

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. Do ask if you have any further questions. The staff at Addenbrooke's are here to help you. **You have the right to change your mind at any time before the procedure is undertaken, including after you have signed this form.**

Training doctors and other health professionals is essential to the continuation of the Health Service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor. You may, however, decline to be involved in the formal training of medical and other students without this adversely affecting your care and treatment.

**I understand** that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

**I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person undertaking the procedure will, however, have appropriate experience.

**I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

**I have been told** about additional procedures which may become necessary during my treatment. I have listed below any procedures that **I do not wish, without further discussion, to be carried out.**

**I understand** that any tissue (including blood) apart from the fetus, removed as part of the procedure or treatment will be anonymised and may be used for teaching or quality control, and stored or disposed of in a manner regulated by appropriate, ethical, legal and professional standards.

**I understand** that all research will be approved by a research ethics committee and undertaken in accordance with appropriate ethical, legal and professional standards.

**I understand** that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory.

**Please tick boxes to indicate you either agree/disagree to the three points below. Yes No**

**I agree** that tissue (including blood) apart from the fetus, not needed for my own diagnosis or treatment can be used for **research which may include genetic research. If you wish** to withdraw your consent for the use of your tissue (including blood) for research, please contact the Patient Advice and Liaison Service at Addenbrooke's Hospital.

**I confirm** that the risks, benefits and alternatives of this procedure have been discussed with me and I have read and understood the above and agree to the procedure (or course of treatment) on this form.

**Patient's signature:** ..... **Date:** .....

**Name (PRINT):** .....

If the patient is unable to sign but has indicated his/her consent, a witness should sign below. Young people may also like a parent to sign here (see guidance notes).

**Witness' signature:** ..... **Date:** .....

**Name (PRINT):** .....

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)  
On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

**Signature:** ..... **Date:** .....

**Name (PRINT):** ..... **Job Title:** .....

## Patient agreement to investigation or treatment

# Mid trimester termination of pregnancy with Prostaglandin. Pre-treatment with Mifepristone.

**Authors:** Gynaecological Services

### Brief description:

- The purpose of this treatment is to induce 'labour' and so cause you to miscarry your pregnancy. This is brought about with the Prostaglandin treatment. The pre-treatment with Mifepristone one or two days before makes the womb more sensitive to the Prostaglandin treatment. This makes the Prostaglandin part of the treatment more effective, and so shortens the length of time you need to be in hospital.
- Here, we explain some of the aims, benefits, risks and alternatives to this procedure (treatment). We want you to be informed about your choices to help you to be fully involved in making any decisions.
- Please ask about anything you do not fully understand or wish to have explained in more detail.
- If you would like this information in another format or language or would like help completing the form, please ask a member of our staff.

### Please bring this form with you to hospital

- You will be asked to read this form carefully, and you and your doctor (or other appropriate healthcare professional) will sign it to document your consent.
- All our consent forms are available on the Addenbrooke's website: <http://www.cuh.org.uk/consent>.
- Remember, you can change your mind about having the procedure at any time.

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### For staff use:

Does the patient have any special requirements? (For example, requires an interpreter or other additional communication method)

.....  
.....

## About mid trimester termination of pregnancy with Prostaglandin. Pre-treatment with Mifepristone

### Contact telephone numbers:

Daphne Ward: 01223 217636 (08:00-20:00 hours, Monday to Friday, 08:30 – 14:00 Saturdays and Sundays. Closed Bank Holidays) or  
Inpatient Gynaecology Ward: 01223 348544 (all other times)

### 1) First appointment – Taking the Mifepristone tablet

Please come to Daphne ward between 10:00 – 16:00 hours

On .....day, date.....

### Before your procedure

- **Things to avoid:** You are advised not to smoke or drink alcohol for at least four hours before this appointment and until you have been discharged following the second part of the treatment (having the vaginal tablets). If you really cannot manage not to smoke, then you should cut down as much as possible, and smoke only half of each cigarette.
- **What if I change my mind?**  
**You must not take the Mifepristone tablet if you have any doubts about having the termination.** The nurse will give you time to discuss any questions or anxieties you may have, but, in the end, only you can make the right decision for yourself.
- If Mifepristone is taken, the pregnancy is very likely to end. There is no available method of preventing, or reversing, the action of Mifepristone, once it is taken.

### During the procedure

- You should expect to stay with us for about one hour. You are welcome to bring your partner or a friend with you. You should have something light to eat, such as tea and toast or a sandwich, before you come for your appointment. This will reduce the risk of you being sick after you have taken the tablet. If you have already been experiencing a lot of pregnancy sickness, please let us know. We can then give you some anti-sickness medication. We will ask you to wait on the ward for about 20 minutes after you have taken the tablet.

### After the procedure: What to expect in the next few days

- **Bleeding:** It is unlikely that you will bleed at this stage. However, if you do, then it is important to use sanitary towels and not tampons.
- **Discomfort:** Rarely women experience cramp-like discomfort, similar to period pains. You **must not** take Aspirin, Ponstan or Ibuprofen (Nurofen) - painkillers that are in the non steroidal anti inflammatory group – as they can stop the Mifepristone tablet from working properly. **You can use Paracetamol or codeine-based painkillers** instead.

- **Miscarriage risk:** It is extremely rare for a woman at your stage of pregnancy to miscarry at home before the second part of the treatment. If this happens, you may bleed heavily and the miscarriage may not be complete. We recommend that you seek medical help urgently. Please do not hesitate to telephone us if you are unsure what to do.

## 2. Admission for prostaglandin treatment

Please come to Daphne ward at **08:30 hours** On .....day,  
date.....

Have a light breakfast beforehand.

### Before your procedure

- **What do I need to bring?** Wear loose, comfortable clothes and bring a spare pair of pants with you. You cannot use tampons but you can provide your own sanitary towels if you prefer, though please do not use the highly absorbent type (for example: 'Always') as they make it difficult to check on how much you are bleeding. Please bring items such as a toothbrush and nightwear in case you need to stay in overnight.
- You will have access to your own television and telephone via pay cards. The radio is free. Bring in some magazines or something else to pass the time. There are water dispensers and a hot-drinks machine that you can help yourself to throughout the day. These facilities are free.
- **Can I bring someone with me?** You can bring your partner or one friend with you, and they are very welcome to stay throughout the day. Please note that we do not have the facilities to care for children on the ward or to have them for long periods of time on the ward as it disturbs other patients. Please make your own arrangements for child-care before attending the hospital.

### During the procedure

- **Taking the Prostaglandin tablets:** Your nurse will go through the procedure with you. After a few checks she will insert the prostaglandin tablets into your vagina. You will need to remain on the bed for one hour after this to allow the tablets to stay in place. The tablets cause your womb to contract, and these contractions will feel like strong period pains. If you can, it is best to try and tolerate some discomfort, as this will make the treatment work more quickly, but your nurse will give you painkillers when you need them. You will be given further doses of Prostaglandin tablets by mouth every three hours, up to a total of five doses, until the termination is complete. The tablets can cause some side-effects; diarrhoea, nausea, dizziness and hot flushes may occur. The side-effects do not last for very long, and if you have any of these symptoms the nurses will do all they can to make sure you are as comfortable as possible.

- Occasionally at the end of the procedure, if the placenta is not expelled from the womb then it is necessary to do a small operation to remove it. If this is done it will be performed under general anaesthetic and you will need to stay overnight.

## After the procedure

- It is very important that the nurses check to see what you are passing. You will be asked to pass water or open your bowels into a cardboard bedpan that fits into the toilet bowl. You must not flush anything down the toilet. You will not have to see anything that comes away; the nurses will be on hand to take away any bedpans that you may have used. If you change your sanitary towel please show it to the nurse before putting it in the bin. This will help us monitor your blood loss accurately.
- **Eating and drinking:** You can eat and drink as long as you are not feeling sick. It is best to have only a light diet during the day.
- **Getting around and about:** You can walk around the ward if you wish after the first hour and this may help the treatment work more quickly, but please do not leave the ward without speaking to your nurse first.
- **When you can leave hospital:** You will not be discharged until the termination is complete. We will arrange for you to be examined before you go, and your nurse will do a final check and give you discharge advice. Women whose blood group is rhesus negative will be given an injection of anti-D before leaving to protect future pregnancies from being affected by rhesus incompatibility. It is sensible to have someone travel home with you. You should be able to leave the ward by early evening, but please remember that some patients have to stay overnight. In case this happens, you should make any necessary arrangements beforehand. This is especially important if you have children at home who will need to be cared for.
- **When you can resume normal activities including work:** You should plan to rest at home for the next 24 hours. If you have young children it is advisable to have another adult around to help you or indeed give you a rest. After this you should be able to resume normal activities, but if you have a physically demanding job you may want to arrange a further day off work.
- **Special measures you need to take after the procedure:**
  - **Bleeding:** You will have some bleeding for 10-14 days following this procedure. Do not have intercourse and do not use tampons; this is to reduce the risk of getting an infection.
  - **Pain:** If you have any discomfort when you get home, you can now use any painkillers you wish.
  - **Hygiene:** It is safe for you to have a warm bath or, preferably, a shower when you get home.
  - **Signs of Infection:** Increased bleeding or pain, or developing a smelly vaginal discharge could be symptoms of an infection. You should see your GP immediately if you develop any of these symptoms, as you may need antibiotic treatment. If your GP is concerned you will be referred back to our team for further management.
  - **Contraception:** You can fall pregnant again very soon after having a termination, so it is important that you use your chosen method of contraception carefully.

- If you have decided to take the progestogen only oral contraceptive pill, you should start it on the same day you leave the hospital.
- If you want to use a coil (IUD) or cap, you should make an appointment with your GP or Family Planning Clinic to arrange this once you have stopped bleeding.
- The injection method (Depo-Provera) can be given to you before you leave the hospital, if you have discussed this with the doctor at the Termination Referral clinic visit and it has been prescribed for you.
- If you want to use condoms, remember to ask the nurse on the ward for a supply if you need them.
- **Check-ups and results:** It is normally a good idea to see a doctor or nurse two to three weeks after a termination of pregnancy. This allows them to check that you are physically and emotionally okay, and is also a good time to sort out future contraception if that has not already been done. You are advised to make an appointment to see your GP for this. Alternatively, you can make an appointment at the **Family Planning Clinic at the Laurels, 20 Newmarket Road**. The clinic telephone number is **08456 50 51 52**.
- **How will I feel emotionally?** It is not unusual to feel low after having a termination, although for most women the overwhelming feeling is one of relief. It is okay for you to feel sad and upset about the whole episode, but if you think that you feel particularly low or even depressed, please do ask for help from your GP or Family Planning Clinic.

## Alternative procedures that are available

- Any alternative procedures to this non-surgical termination depend on the stage of your pregnancy. These options will be discussed with you in detail at the clinic.

## Serious or frequently occurring risks

- Complications are rare, but may include excessive vaginal bleeding requiring transfusion.
- Rarely, women do not go into labour following the full course of prostaglandins. If this happens, the whole procedure is repeated the next day. Extremely rarely this too does not work and it is necessary to do an operation through the abdomen to remove the pregnancy (like a caesarean section).

## Disposal of foetal tissue

### Arrangements for disposal of the fetal remains:

There are standard procedures in place for the disposal of fetal remains which are described briefly below. If you wish to obtain more detailed information of the processes, please contact one of the people named at the end of this document:

- Fetal remains below 13 weeks gestation are cremated within the hospital, in accordance with the relevant code of practice. This is planned and organised to ensure that no other material is dealt with at the same time. The process is witnessed by two members of the bereavement team.

- Fetal remains above 13 weeks gestation are cremated at the local crematorium in a monthly group service taken by the lead Chaplain for the Trust. In order to maintain patient confidentiality the patient's name is not used to identify the remains.
- A woman or couple may decide to make arrangements themselves, either at home or in a local cemetery/crematorium using a funeral director. To arrange this please contact one of the people listed below, prior to the procedure.

If you wish to discuss any of the above, or to have further Information, please contact Daphne Ward staff (01223 217636)



We are currently working towards a smoke free site. Smoking is only permitted in the designated smoking areas.

For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169

#### Help with this leaflet:



If you would like this information in another language, large print or audio format, please ask the department to contact Patient Information: 01223 216032 or [patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)



#### Document history

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Version number/Ref	4/CF237

Consent form 1

# Patient agreement to investigation or treatment

<b>For staff use only:</b>	
<b>Surname:</b>	
<b>First names:</b>	
<b>Date of birth:</b>	
<b>Hospital no:</b>	
<b>Male/Female:</b>	
<b>(Use hospital identification label)</b>	

Responsible health professional/job title

Special requirements .....  
(For example, other language/other communication method)

**Name of proposed procedure or course of treatment**

**Mid trimester termination of pregnancy with Prostaglandin. Pre-treatment with Mifepristone**

**Statement of health professional**

(To be filled in by a health professional with an appropriate knowledge of the proposed procedure, as specified in the Hospital's consent policy)

I have explained the procedure to the patient. In particular, I have explained:

- The intended aim of the procedure: Termination of pregnancy .....

- Any serious or frequently occurring risks from the procedures including those specific to the patient: Excessive vaginal bleeding. Rarely, women do not go into labour following the full course of prostaglandins. If this happens, the whole procedure is repeated the next day. Extremely rarely this too does not work and it is necessary to do an operation through the abdomen to remove the pregnancy (like a caesarean section).

- Any extra procedures that might become necessary during the procedure

Blood transfusion  Other procedure (please specify) .....

I have discussed what the treatment / procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following information leaflet has been provided: Mid trimester termination of pregnancy with Prostaglandin. Pre-treatment with Mifepristone.

Version/Date/Ref: 4, October 2011, CF237 .....

This procedure will involve:

- General and/or regional anaesthesia     Local anaesthesia     Sedation

Health professional's signature: ..... Date: .....

Name (PRINT): ..... Job title: .....

Contact details (if patient wishes to discuss details later)

I have offered the patient information about the procedure but s/he has declined information.

**Statement of the interpreter (if appropriate)**

I have interpreted the information to the best of my ability, and in a way in which I believe s/he can understand:

Interpreter's signature ..... Date: .....

Name (PRINT): .....

**Important notes: (tick if applicable)**

- The patient has withdrawn consent (ask patient to sign/date here) .....
- See also advance directive/living will (e.g. Jehovah's Witness form)

Copy accepted by patient: yes / no (please circle)

<b>For staff use only:</b>
<b>Surname:</b>
<b>First names:</b>
<b>Date of birth:</b>
<b>Hospital no:</b>
<b>Male/Female:</b>
<b>(Use hospital identification label)</b>

**Statement of patient**

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. Do ask if you have any further questions. The staff at Addenbrooke's are here to help you. **You have the right to change your mind at any time before the procedure is undertaken, including after you have signed this form.**

Training doctors and other health professionals is essential to the continuation of the Health Service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor. You may, however, decline to be involved in the formal training of medical and other students without this adversely affecting your care and treatment.

**Please read the following:**

**I understand** that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

**I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person undertaking the procedure will, however, have appropriate experience.

**I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

**I have been told** about additional procedures which may become necessary during my treatment. I have listed below any procedures that **I do not wish, without further discussion, to be carried out.**

**I understand** that any tissue (including blood) apart from the foetus, removed as part of the procedure or treatment will be anonymised and may be used for teaching or quality control, and stored or disposed of in a manner regulated by appropriate, ethical, legal and professional standards.

**I understand** that all research will be approved by a research ethics committee and undertaken in accordance with appropriate ethical, legal and professional standards.

**I understand** that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory.

**Please tick boxes to indicate you either agree/disagree to the three points below. Yes No**

**I agree** that tissue (including blood) apart from the foetus not needed for my own diagnosis or treatment can be used for **research which may include genetic research.** If you wish to withdraw your consent for the use of your tissue (including blood) for research, please contact the Patient Advice and Liaison Service at Addenbrooke's Hospital.

**I confirm** that the risks, benefits and alternatives of this procedure have been discussed with me and I have read and understood the above and agree to the procedure (or course of treatment) on this form.

**Patient's signature:** ..... **Date:** .....

**Name (PRINT):** .....

If the patient is unable to sign but has indicated his/her consent, a witness should sign below. Young people may also like a parent to sign here (see guidance notes).

**Witness' signature:** ..... **Date:** .....

**Name (PRINT):** .....

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

**Signature:**..... **Date:** .....

**Name (PRINT):** ..... **Job Title:** .....

## Patient agreement to investigation or treatment

# Termination of early pregnancy with Mifepristone and Prostaglandin

**Authors:** Gynaecological Services

**Brief description:**

- You have chosen a non-surgical procedure for the termination of your pregnancy. The procedures will be performed in two stages at the hospital.
- Here, we explain some of the aims, benefits, risks and alternatives to this procedure (operation/treatment). We want you to be informed about your choices to help you to be fully involved in making any decisions.
- Please ask about anything you do not fully understand or wish to have explained in more detail.
- If you would like this information in another format or language or would like help completing the form, please ask a member of our staff.

**Please bring this form with you to hospital**

- You will be asked to read this form carefully, and you and your doctor (or other appropriate healthcare professional) will sign it to document your consent.
- All our consent forms are available on the Addenbrooke's website:  
<http://www.cuh.org.uk/consent>
- Remember, you can change your mind about having the procedure at any time.

---

**For staff use:**

Does the patient have any special requirements? (For example requires an interpreter or other additional communication method)

.....  
.....

## About termination of pregnancy with Mifepristone and Prostaglandin

- This is a two stage procedure. The first stage of the treatment requires a hospital visit of approximately one hour and involves taking the Mifepristone tablet which blocks the action of the hormone progesterone, which is needed to sustain a pregnancy. This results in:
  - Changes in the womb lining and detachment of the pregnancy.
  - Softening and opening of the neck of womb.
- The second part of the procedure involves having Prostaglandin tablets inserted into the vagina which causes the womb to contract, and helps the pregnancy tissue to pass. You should expect to be in hospital for up to a whole day for the treatment.

### Contact telephone numbers:

Daphne Ward: 01223 217636 (08:00-20:00 hours, Monday to Friday, 08:30-14:00, Saturday & Sunday) or Ward L4: 01223 348500 (all other times)

### 1) First appointment – Taking the Mifepristone tablet

Please come to Daphne ward between 10:00 – 16:00 hours

On .....day, ..... date.....

### Before your procedure

- **Things to avoid:** You are advised not to smoke or drink alcohol for at least four hours before this appointment and until you have been discharged following the second part of the treatment (having the vaginal tablets). If you really cannot manage not to smoke, then you should cut down as much as possible, and smoke only half of each cigarette.
- **What if I change my mind?**  
**You must not take the Mifepristone tablet if you have any doubts about having the termination.** The nurse will give you time to discuss any questions or anxieties you may have, but, in the end, only you can make the right decision for yourself.  
If Mifepristone is taken, the pregnancy is very likely to end. There is no available method of preventing, or reversing, the action of Mifepristone, once it is taken.

### During the procedure

- You should expect to stay with us for about one hour. You are welcome to bring your partner or a friend with you. You should have something light to eat, such as tea and toast or a sandwich before you come for your appointment. This will reduce the risk of you being sick after you have taken the tablet. If you have already been experiencing a lot of pregnancy sickness, please let us know. We can then give you some anti-sickness medication.

We will ask you to wait on the ward for about 20 minutes after you have taken the tablet.

### After the procedure: What to expect in the next few days

- **Bleeding:** You may have some vaginal bleeding in between your two visits. This is most likely to happen about 36 hours after taking the Mifepristone tablet. Not all women will bleed before their next visit. If you do have any bleeding, it is important to use sanitary towels and not tampons.
- **Discomfort:** Some women experience cramp-like discomfort, similar to period pains. You must not take Aspirin, Ponstan or Ibuprofen (Nurofen) - painkillers that are in the non steroidal anti inflammatory group (NSAIDS) - as they can stop the Mifepristone tablet from working properly. You can use Paracetamol or codeine-based painkillers instead.
- **Miscarriage Risk:** A few women have heavy blood loss at home and some actually miscarry before coming in for the second part of the treatment. If this happens, we cannot be sure that you have had a complete miscarriage, therefore it is important that you still come in for your second visit to complete the treatment. This will reduce the chances of having problems in the future. We understand that bleeding heavily at home can be quite frightening; please do not hesitate to telephone us if you are unsure what to do.

### 2) Admission for prostaglandin treatment

Please come to Daphne ward at 08:30 hours

On ..... day, ..... date.....

Have a light breakfast beforehand.

### Before your procedure

- **What do I need to bring?** Wear loose, comfortable clothes and bring a spare pair of pants with you. You cannot use tampons and high absorbency sanitary towels are advisable, such as: 'Always'.
- You will have access to your own television and telephone via pay cards. The radio is free. Bring in some magazines or something else to pass the time. There are water dispensers and a hot drinks machine that you can help yourself to throughout the day. These facilities are free.
- **Can I bring someone with me?** You can bring your partner or one friend with you and they are very welcome to stay throughout the day. Please note that we do not have the facilities to care for children on the ward. Please make your own arrangements for child-care before attending the hospital.

## During the procedure

- **Taking the Prostaglandin tablets:** Your nurse will go through the procedure with you. After a few checks she will insert the prostaglandin tablets into your vagina. You will need to remain on the bed for one hour after this to allow the tablets to stay in place. The tablets open up the neck of the womb (the cervix), and this will cause some period-type pain and increased bleeding. If you can, it is best to try and tolerate some discomfort, as this will make the treatment work more quickly. If you get too uncomfortable, however, we can give you some painkillers.
- The tablets can cause some side effects: diarrhoea, nausea, dizziness and hot flushes which do not last for very long. If you have any of these symptoms the nurses will do all they can to make sure you are as comfortable as possible.

## After the procedure

- It is very important that the nurses check to see what you are passing. You will be asked to pass water or open your bowels into a cardboard bedpan that fits into the toilet bowl. You must not flush anything down the toilet. You will not have to see anything that comes away; the nurses will be on hand to take away any bedpans that you may have used. If you change your sanitary towel please show it to the nurse before putting it in the bin. This will help us monitor your blood loss accurately.
- **Eating and drinking:** You can eat and drink as long as you are not feeling sick. It is best to have only a light diet during the day.
- **Getting around and about:** You can walk around the ward if you wish and this may help the treatment work more quickly, but please do not leave the ward without speaking to your nurse first.
- **When you can leave hospital:** It is safe to go home after a few hours as long as you are not bleeding too heavily. You should be able to leave the ward by middle to late afternoon. Most patients will miscarry before they go home. Occasionally this is delayed until after the patient has returned home. Very rarely there is no bleeding at all while you are on the ward. If this happens the nurse will explain to you what to do.
- We will arrange for you to be examined before you go, and your nurse will do a final check and give you discharge advice. Women whose blood group is rhesus negative will be given an injection of anti-D before leaving to protect future pregnancies from being affected by rhesus incompatibility. It is sensible to have someone travel home with you.
- **When you can resume normal activities including work:** You should be able to resume normal activities the following day, but if you have a physically demanding job you may want to arrange a further day off work.
- **Special measures you need to take after the procedure:**
  - **Bleeding:** You will have some bleeding for a week to two weeks following this procedure. Do not have intercourse and do not use tampons to reduce the risk of getting an infection.

- **Pain:** If you have any discomfort when you get home, it is best to avoid Aspirin and Nurofen type drugs (NSAIDS) during the first week. Paracetamol or codeine should control any pain you might have.
- **Hygiene:** It is safe for you to have a warm bath or, preferably, a shower when you get home.
- **Signs of Infection:** Increased bleeding or pain, or developing a smelly vaginal discharge could be symptoms of an infection. You should see your GP immediately if you develop any of these symptoms, as you may need antibiotic treatment. If your GP is concerned you will be referred back to our team for further management.
- **Contraception:** You can fall pregnant again very soon after having a termination, so it is important that you use your chosen method of contraception carefully. If you have decided to take the oral contraceptive pill, you should start it on the same day you leave the hospital. If you want to use a coil (IUD) or cap, you should make an appointment to discuss this at the family planning clinic or your GP's surgery, in two to three week's time. The injection method (Depo-Provera) can be given to you before you leave the ward, if it has already been discussed with the doctor at the TR clinic and prescribed for you. Alternatively it can be given at your GP surgery or at the Family Planning Clinic when you have your next period. If you want to use condoms, remember to ask the nurse on the ward for a supply if you need them.
- **Check-ups and results:** Most patients don't need to come back to the hospital for a check-up, but in a few cases it is necessary to see you again to make sure the termination is complete. If this is necessary in your case, then your nurse will explain this to you and give you a date and time to return before you leave the ward after the prostaglandin treatment.
- It is normally a good idea to see a doctor or nurse two to three weeks after a termination of pregnancy. This allows them to check that you are physically and emotionally OK, and is also a good time to sort out future contraception if that hasn't already been done. You are advised to make an appointment to see your GP for this. Alternatively, you can make an appointment at the **Family Planning Clinic at the Laurels, 20 Newmarket Road**. The clinic telephone number is **08456 50 51 52**.
- **How will I feel emotionally?** It is not unusual to feel low after having a termination, although for most women the overwhelming feeling is one of relief. It is okay for you to feel sad and upset about the whole episode, but if you think that you feel particularly low or even depressed, please do ask for help from your GP or Family Planning Clinic.

### Alternative procedures that are available

- Any alternative procedures to this non-surgical termination depend on the stage of your pregnancy. These options will be discussed with you in detail at the clinic.

### Serious or frequently occurring risks

- After taking the prostaglandin, you will experience lower abdominal cramping pain and vaginal bleeding. You may also experience nausea, vomiting, and diarrhoea, which may be severe in some cases.

- Complications are rare, but may include excessive vaginal bleeding requiring transfusion (occurs in approximately 1 in 500 cases).
- Extensive studies have shown that occasionally this treatment does not work and the abortion may have to be completed with a standard, surgical procedure. In up to 5% of cases the miscarriage is incomplete and you may need further treatment in hospital.

## Disposal of foetal tissue

### Arrangements for disposal of the fetal remains:

There are standard procedures in place for the disposal of fetal remains which are described briefly below. If you wish to obtain more detailed information of the processes, please contact one of the people named at the end of this document:

- Fetal remains below 13 weeks gestation are cremated within the hospital, in accordance with the relevant code of practice. This is planned and organised to ensure that no other material is dealt with at the same time. The process is witnessed by two members of the bereavement team.
- Fetal remains above 13 weeks gestation are cremated at the local crematorium in a monthly group service taken by the lead Chaplain for the Trust. In order to maintain patient confidentiality the patient's name is not used to identify the remains.
- A woman or couple may decide to make arrangements themselves, either at home or in a local cemetery/crematorium using a funeral director. To arrange this please contact one of the people listed below, prior to the procedure.

If you wish to discuss any of the above, or to have further information, please contact Daphne Ward staff (ext. 3636), one of the Chaplaincy team (ext. 3769), the Midwifery Counsellor (ext. 3882), or the Bereavement Coordinator (ext. 3619).



We are currently working towards a smoke-free site. Smoking is only permitted in the designated smoking areas.

For advice and support in quitting, contact your GP or the free NHS Stop Smoking helpline on 0800 169 0 169

**Help with this leaflet:**



If you would like this information in another language, large print or audio format, please ask the department to contact

Patient Information: 01223 216032 or  
[patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)



**Document history**

Authors	Gynaecological Services
Department	Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ <a href="http://www.cuh.org.uk">www.cuh.org.uk</a>
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Version number/Ref	4/CF236

# Patient agreement to investigation or treatment

<b>For staff use only:</b>	
Surname:	
First names:	
Date of birth:	
Hospital no:	
Male/Female:	
<b>(Use hospital identification label)</b>	

Responsible health professional/job title

Special requirements .....  
(For example other language/other communication method)

**Name of proposed procedure or course of treatment**

## Termination of pregnancy with Mifepristone and Prostaglandin

**Statement of health professional**

(To be filled in by a health professional with an appropriate knowledge of the proposed procedure, as specified in the Hospital's consent policy)

I have explained the procedure to the patient. In particular, I have explained:

- The intended aim of the procedure: Termination of pregnancy.....
  - Any serious or frequently occurring risks from the procedures including those specific to the patient: Lower abdominal cramping pain, vaginal bleeding, excessive vaginal bleeding requiring transfusion, abortion may have to be completed with a standard surgical procedure.
  - Any extra procedures that might become necessary during the procedure
- Blood transfusion    Other procedure (please specify) .....

I have discussed what the treatment / procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following information leaflet has been provided: Termination of early pregnancy with Mifepristone and Prostaglandin

..... Version/Date/Ref: 4, March 2011, CF236 .....

This procedure will involve:

- General and/or regional anaesthesia    Local anaesthesia    Sedation

Health professional's signature: ..... Date: .....

Name (PRINT): ..... Job title: .....  
Contact details (if patient wishes to discuss details later)

I have offered the patient information about the procedure but s/he has declined information.

**Statement of the interpreter (if appropriate)**

I have interpreted the information to the best of my ability, and in a way in which I believe s/he can understand:

Interpreter's signature..... Date: .....

Name (PRINT):.....

**Important notes: (tick if applicable)**

- The patient has withdrawn consent (ask patient to sign/date here) .....
- See also advance directive/living will (eg Jehovah's Witness form)

Copy accepted by patient: yes / no (please circle)

**Statement of patient**

<b>For staff use only:</b>
Surname:
First names:
Date of birth:
Hospital no:
Male/Female:
<b>(Use hospital identification label)</b>

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. Do ask if you have any further questions. The staff at Addenbrooke's are here to help you. **You have the right to change your mind at any time before the procedure is undertaken, including after you have signed this form.**

Training doctors and other health professionals is essential to the continuation of the Health Service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor. You may, however, decline to be involved in the formal training of medical and other students without this adversely affecting your care and treatment.

**Please read the following:**

**I understand** that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

**I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person undertaking the procedure will, however, have appropriate experience.

**I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

**I have been told** about additional procedures which may become necessary during my treatment. I have listed below any procedures that **I do not wish, without further discussion, to be carried out.**

**I understand** that any tissue (including blood) apart from the foetus, removed as part of the procedure or treatment will be anonymised and may be used for teaching or quality control, and stored or disposed of in a manner regulated by appropriate, ethical, legal and professional standards.

**I understand** that all research will be approved by a research ethics committee and undertaken in accordance with appropriate ethical, legal and professional standards.

**I understand** that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory.

**Please tick boxes to indicate you either agree/disagree to the three points below. Yes No**

**I agree** that tissue (including blood) apart from the foetus not needed for my own diagnosis or treatment can be used for **research which may include genetic research.** If you **wish** to withdraw your consent for the use of your tissue (including blood) for research, please contact the Patient Advice and Liaison Service at Addenbrooke's Hospital.

**I confirm** that the risks, benefits and alternatives of this procedure have been discussed with me and I have read and understood the above and agree to the procedure (or course of treatment) on this form.

**Patient's signature:** ..... **Date:** .....

**Name (PRINT):** .....

If the patient is unable to sign but has indicated his/her consent, a witness should sign below. Young people may also like a parent to sign here (see guidance notes).

**Witness' signature:** ..... **Date:** .....

**Name (PRINT):** .....

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)  
On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature.... **Date:** .....

**Name (PRINT):** ..... **Job Title:** .....

**Obstetrics & Gynaecology Directorate**  
**Consent Form - Disposal of Fetal Remains**

Patient name: .....

Hospital number: .....

Address: .....

.....

Post Code: .....

Consultant: .....

I confirm that I have read and understood the information given about the disposal of fetal remains and that any questions I have asked have been answered to my satisfaction and understanding.

**A. If fetal remains are below 11 weeks, 6 days**

I consent to the hospitals standard procedure for cremation and I understand that the ashes cannot be returned to me.

I wish to take the fetal remains and make arrangements myself.

**B. If fetal remains are between 12 weeks and 23 weeks, 6 days**

I wish for the hospital to arrange burial at a local cemetery. I understand I will be contacted with the arrangements.

I wish to take the fetal remains and make arrangements myself.

Patient signature: .....

Print name: .....

Date: .....

**Doctor/healthcare professional taking consent**

Signature: .....

Print name: .....

Date: .....

Job title: .....



# **Medical Management of Miscarriage**

Northampton   
General Hospital  
NHS Trust

## Introduction

We are sorry you have experienced a miscarriage of pregnancy. Your scan shows some of the 'tissue' from the pregnancy has retained in your womb. The purpose of this leaflet is to help you to understand the treatment you are to receive.

After a woman has a miscarriage, there can be some tissue and blood clot left in her Uterus (womb). This tissue and blood may pass naturally or there is an operation to remove this. You can also have medication to empty the womb.

Here we explain some of the aims, benefits, risks and alternatives to this procedure (operation/treatment). We want you to be informed about your choices to help you to be fully involved in making any decisions.

Please ask about anything you do not fully understand or wish to have explained in more detail. If you would like help completing the form, please ask a member of our staff.

## Before the procedure

Most patients are seen in the Emergency Gynaecology Clinic where you will meet one of the nurses and/or doctor.

At this time, we shall ask you for details of your medical history and carry out any necessary clinical examinations and investigations. This is a good opportunity for you to ask us any questions about the procedure, but please feel free to discuss any concerns you may have at any time.

You will be asked if you are taking any tablets or other types of medication - these might be ones prescribed by a doctor or bought over the counter in a pharmacy. It helps us if you bring details with you of anything you are taking (for example: bring the packaging with you).

It is important that you tell the nurse or doctor looking after you about any previous or current health problems you have, in particular raised blood pressure, heart disease, asthma, liver or kidney disease or a problem with blood clotting.

## During the procedure

You will be given a tablet to be taken orally called Mifepristone which helps the womb to respond to the next part of the treatment. A small number of women will miscarry or start to bleed after this tablet.

Occasionally this tablet causes nausea so you will be asked to remain on the ward for at least 20 minutes after having taken it. Most women are able to go home 30 minutes after having taken the Mifepristone tablet.

You will be asked to return to the ward two to three days later. The nurse looking after you will tell you when this should be.

On this admission you will be given Prostaglandin tablets (Misoprostol) which are placed in the vagina. Misoprostol opens the cervix (the neck of the womb) to allow the retained tissue to pass.

The Misoprostol tablets are not licensed for use in this way, however, they are widely used across the country for medical management of miscarriage. There is good evidence of safety and effectiveness and use is supported by the Royal College of Obstetricians and Gynaecologists. If you have concerns about this and wish to receive a licensed alternative, please discuss this with your doctor.

It is usual to experience some bleeding and cramping pain. You will be offered painkillers if required. Some women experience side effects from the Misoprostol. The most common are nausea, diarrhoea, dizziness and hot flushes.

You will be required to stay on the ward for at least six hours.

If you have medical management or your blood type is rhesus negative, you will be given an injection of anti-D Immunoglobulin to prevent antibodies forming which may affect later pregnancies.

## After the procedure

It is very important that the nurses check what you are passing. You will be allowed to pass water or open your bowels into a cardboard bedpan that fits in to the toilet bowl. You must not flush anything down the toilet. You will not have to see anything that comes away, the nurses will be on hand to take away any bedpans that you may have used. If you change your sanitary towel please show it to the nurse before putting it in the bin. This will help us monitor your blood loss accurately.

**Eating and drinking:** You can eat and drink as long as you are not feeling sick. It is best to have only a light diet during the day.

**Getting around and about:** You can walk around the ward if you wish and this may help the treatment work more quickly, but please do not leave the ward without speaking to your nurse first.

**When can you leave the hospital?:** It is safe to go home after a few hours as long as you are not bleeding too heavily. Most patients will miscarry before they go home. Occasionally this is delayed until after the patient has returned home. Very rarely there is no bleeding at all while you are on the ward. If this happens the nurse will explain what to do.

Women whose blood group is Rhesus negative will be given an injection of anti-D before leaving to protect future pregnancies from being affected by Rhesus incompatibility. You will be given oral antibiotics to take home. You will need to make arrangements for transport home, a friend or relative will need to collect you in a car, and look after you at home for 24 hours. Otherwise you may have to stay on the ward overnight.

**When can you resume normal activities including work?** You should be able to resume normal activities the following day, but if you have a physically demanding job you may want to arrange a further day off work.

## Measures you will need to take

**Bleeding:** You will have some bleeding for one or two weeks following this procedure. To reduce the risk of getting an infection, do not have intercourse and do not use tampons.

**Pain:** If you have any discomfort when you get home, it is best to avoid Aspirin and Nurofen type drugs (NSAIDS) during the first week. Paracetamol or Codeine should control any pain you might have.

**Hygiene:** It is safe for you to have a warm bath or, preferably, a shower when you get home.

**Signs of infection:** Increased bleeding or pain, or developing a smelly vaginal discharge could be symptoms of an infection. You should see your GP immediately if you develop any of these symptoms, as you may need antibiotic treatment. If your GP is concerned you will be referred back to our team for further management.

**Check ups and results:** You will need to return to the Gynaecology Unit for an ultrasound scan to make sure the miscarriage is complete. The nurse will discuss this with you before you are discharged.

## Risks and benefits of the procedure

### Benefit

To empty the uterus (womb) of any remaining tissue and blood clot after a miscarriage.

### Serious or frequently occurring risks

This is a very safe procedure, however, like all procedures there are potential risks involved. The main risks of the procedure are:

- After taking the Prostaglandin, you will experience lower abdominal cramping pain and vaginal bleeding. You may also experience nausea, vomiting and diarrhoea which may be severe in some cases.
- Complications are rare, but may include excessive vaginal bleeding requiring transfusion (occurs in approximately 1 in 500 cases)
- Extensive studies have shown that occasionally this treatment doesn't work and the termination may have to be completed with u89a standard, surgical procedure. In up to 5% of cases the miscarriage is incomplete and you may need further treatment in hospital.

Do not hesitate to contact your GP if you feel unwell.

## Disposal of fetal tissue

There are standard procedures in place for the disposal of fetal remains which are described below. If you wish to obtain more detailed information of the processes, please contact one of the people named at the end of this document.

- Fetal remains under 11 weeks, 6 days gestation are cremated in a sensitive manner, in accordance with the relevant codes of practices. This process is planned and organised to ensure that no other material is dealt with at the same time. Any ashes from this process cannot be returned to you
- Fetal remains between 12 weeks and 23 weeks, 6 days are buried at a local cemetery. This service is organised by the hospital chaplain
- You may decide to make arrangements yourself, either at home or in a local cemetery/crematorium using a funeral director. To arrange this please speak to one of the people listed below, prior to the procedure

## Finally

If you wish to discuss any of the above, or to have further information, please contact:

Spencer Ward	(01604) 544610
Obstetric and Gynaecology counsellor	(01604) 545944
Chaplaincy team	(01604) 545773
Bereavement support midwife	(01604) 544777

## Useful websites

[www.nhs.uk](http://www.nhs.uk)

[www.northamptongeneral.nhs.uk](http://www.northamptongeneral.nhs.uk)

## Other information

Northampton General Hospital operates a smoke-free policy. This means that smoking is not allowed anywhere on the trust site, this includes all buildings, grounds and car parks.

Leaflets, information, advice and support on giving up smoking and on nicotine replacement therapy are available from the local Stop Smoking helpline on 0845 601 3116, the free national helpline on 0800 169 0169, e-mail: [smokefree@northants.nhs.uk](mailto:smokefree@northants.nhs.uk) and local pharmacies.

Car parking at Northampton General Hospital is extremely limited and it is essential to arrive early, allowing ample time for parking. Alternatively, you may find it more convenient to arrange to be dropped off and collected.

This information can be provided in other languages and formats upon request including Braille, audio cassette and CD. Please contact (01604) 544516 or the Patient Advice & Liaison Service (PALS) on (01604) 545784, e-mail: [Pals@ngh.nhs.uk](mailto:Pals@ngh.nhs.uk)

Northampton General Hospital NHS Trust, Cliftonville, Northampton NN1 5BD.

Desktop Publishing by Medical Illustration

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**OBSTETRICS & GYNAECOLOGY**

**PATIENT INFORMATION**



# **Surgical Termination of Pregnancy**

Northampton **NHS**  
General Hospital

NHS Trust

## Introduction

The Purpose of this treatment is to surgically remove your pregnancy. The operation will be performed under a general anaesthetic and you should expect to be in hospital for up to 12 hours.

Here, we explain some of the aims, benefits, risks and alternatives to this procedure (operation/treatment). We want you to be informed about your choices to help you to be fully involved in making any decisions.

Please ask about anything you do not fully understand or wish to have explained in more detail.

If you would like help completing any forms, please ask a member of our staff.

## Before your procedure

You will be seen at the Gynaecology Outpatient Clinic, where you will meet nurses and doctors who are specialists in gynaecology.

At this clinic, we shall ask you for details of your medical history and carry out any necessary clinical examinations and investigations. This is a good opportunity for you to ask us any questions you have about the procedure, but please feel free to discuss any concerns you may have at any time.

You will be asked if you are taking any tablets or other types of medication, these might be ones prescribed by a doctor or bought over the counter in a pharmacy. It helps us if you bring details with you of anything you are taking (for example: bring the packaging with you).

This procedure involves the use of general anaesthesia. You will be assessed by a nurse/doctor/anaesthetist to ensure you are fit for surgery. This may be done in the Pre-admission Clinic or when you are admitted to the ward.

Usually this operation is performed as a day-case procedure. You will need to make arrangements for transport home. You will need a responsible friend or relative to collect you in a car, and look after you at home for 24 hours after your procedure. If you do not have anybody to care for you at home you will have to stay in hospital overnight.

You **must not** eat or drink anything 6 hours prior to your operation, this includes chewing gum.

Blood will be taken to find out your blood group.

A small vaginal pessary, which is inserted about an hour before the procedure is sometimes required. This helps to dilate the cervix (neck of womb).

### **During your procedure**

You will first be given a general anaesthetic, usually by having an injection into a small vein in the back of your hand.

When you are asleep, first the neck of the womb (cervix) is stretched, and then a soft plastic tube is inserted into the womb (uterus) and the contents are removed by suction (this does not involve the cutting of any tissue).

While you are still under anaesthetic, an antibiotic called Metronidazole (Flagyl) may be given to you rectally (into your back passage). It is absorbed in to your blood stream and helps to reduce the risk of later infection. If you know you are allergic to this antibiotic, or if for any other reason you do not want to have this treatment, you should tell the doctor

## After your treatment

After your operation you will wake up in the recovery room. You might have an oxygen mask on your face to help you breathe. You might also wake up feeling sleepy.

While you are in the recovery room, a nurse will check your pulse and blood pressure regularly. When you are well enough to be moved, you will be taken to a ward.

You may feel sick or vomit after the operation. The nurse can give you medicine to stop this.

If your blood group is rhesus negative you will be given an injection of anti-D before leaving to protect future pregnancies from being affected by rhesus incompatibility.

**Getting around and about:** After this procedure, we will try to get you up and about as soon as we can to prevent complications from lying in bed. Typically you will be able to get up after one hour.

**When you leave the hospital:** You will normally be discharged on the same day as your operation. You should not go home unaccompanied. You will be given oral antibiotics to take home. You will probably still be feeling some discomfort when you are back home. Ordinary painkillers such as paracetamol should help. If the pain becomes distressing you should contact your GP.

**When to resume normal activities including work:** Plan to take it easy at home the day after your operation although you will probably feel well enough to go to work the day after that. For 24 hours following a general anaesthetic you should **NOT:**

- Drive a car or any other vehicle or cycle
- Operate any apparatus or machinery - including a cooker
- Do ANY strenuous exercise
- Drink any alcohol

## Measures you must take

**Bleeding:** You will have some bleeding for up to 10 days following this procedure. The bleeding should gradually lessen. You should use sanitary pads, not tampons, during this time to reduce the risk of infection, so make sure you have some at home.

Your 1<sup>st</sup> period will usually be around six weeks after the procedure.

**Pain:** At first you may have some pain (like period pains), again make sure you have some paracetamol or similar painkillers at home.

**Hygiene:** Because of the risk of infection, you are advised not to have sexual intercourse until several days after the bleeding has stopped. If you do have intercourse during this time, it is advisable to use a condom to reduce the risk of infection, even if you are using another method of contraception.

**Contraception:** A preliminary discussion about future contraception will have taken place in the Gynaecology Outpatient Clinic. If you have not already decided on future contraceptive methods please consult your GP or family planning clinic as soon as possible.

**Sexual intercourse:** So long as you are taking contraceptive precautions it is safe to have sexual intercourse once the bleeding and pain have settled, usually 7-10 days following your procedure.

## Alternative procedures

Any alternative procedures to surgical termination depend on the stage of your pregnancy. These options will be discussed with you in detail at the clinic.

## Risks and benefits

It is reassuring to know that this operation is very safe. However, no procedure is absolutely safe, and it is important that you know what the risks are.

**Infection** can occur in about one in 20 women. If it is untreated it may make it difficult to get pregnant at a later date. If you experience an increase in bleeding, lower abdominal pain, a raised body temperature or a smelly vaginal discharge after your operation you should see your GP immediately so that you can be started on antibiotics. Occasionally, women have to be readmitted to hospital for an infection to be treated more intensely.

**Injury to the cervix or uterus** (womb) at the time of operation may occur in one in 200 cases. In the majority of these, the injury heals itself. If it is thought such an injury may have occurred at the time of your operation, the surgeon may go on to perform a laparoscopic examination (like looking through a telescope) of your abdomen to check whether any damage has occurred which requires further intervention. If further treatment is necessary you may have to be admitted overnight.

**Bleeding** that requires blood transfusion can occur in about one in 500 women. We take blood at your clinic visit and this is held by the laboratory in case you need to have blood urgently cross matched.

**Blood clots** in the veins can occur after most surgical operations, but this is unusual after early terminations.

Overall, the risk to your life from a surgical termination of pregnancy in the first 12 weeks is very low at about one in 100,000. The risk to your life from surgical termination of a full term pregnancy is about eight times higher than the risks of an early termination.

**Failure to terminate the pregnancy** may occur. This is more likely before eight weeks of pregnancy, which is why the operation is not normally performed before this time. However, it can also rarely happen at later dates and so it is important that you consult your GP or Family Planning Clinic for a check up if you continue to feel pregnant. You should expect to have a period about four weeks after the operation.

(Pregnancy tests may continue to show positive for a couple of days after a successful termination).

Do not hesitate to contact your GP if you feel unwell.

## **Disposal of fetal tissue**

There are standard procedures in place for the disposal of fetal remains which are described below. If you wish to obtain more detailed information of the processes, please contact one of the people named at the end of this document.

- Fetal remains under 11 weeks, 6 days gestation are cremated in a sensitive manner, in accordance with the relevant codes of practices. This process is planned and organised to ensure that no other material is dealt with at the same time. Any ashes from this process cannot be returned to you
- Fetal remains between 12 weeks and 23 weeks, 6 days are buried at a local cemetery. This service is organised by the hospital chaplain
- You may decide to make arrangements yourself, either at home or in a local cemetery/crematorium using a funeral director. To arrange this please speak to one of the people listed below, prior to the procedure

## Finally

If you wish to discuss any of the information contained in this leaflet, or to have further information, please contact:

Spencer Ward	(01604) 544610
Obstetric and Gynaecology counsellor	(01604) 545944
Chaplaincy team	(01604) 545773
Bereavement support midwife	(01604) 544777

## Other information

Northampton General Hospital operates a smoke-free policy. This means that smoking is not allowed anywhere on the trust site, this includes all buildings, grounds and car parks.

Leaflets, information, advice and support on giving up smoking and on nicotine replacement therapy are available from the Stop Smoking helpline on 0845 601 3116, the national helpline on 0800 1690169, e-mail: [smokefree@northants.nhs.uk](mailto:smokefree@northants.nhs.uk) and local pharmacies.

Car parking at Northampton General Hospital is extremely limited and it is essential to arrive early allowing ample time for parking. You may find it more convenient to be dropped off and collected.

This information can be provided in other languages and formats upon request. Please contact (01604) 544516 or the Patient Advice & Liaison Service (PALS) on (01604) 545784, e-mail: [Pals@ngh.nhs.uk](mailto:Pals@ngh.nhs.uk)

### Useful websites

[www.nhs.uk](http://www.nhs.uk)

[www.northamptongeneral.nhs.uk](http://www.northamptongeneral.nhs.uk)

Northampton General Hospital NHS Trust, Cliftonville, Northampton NN1 5BD.  
Desktop Publishing by the Medical Illustration Department

NGV468

Updated May 2012

Cormac Jennings

[mrcormacjennings@gmail.com](mailto:mrcormacjennings@gmail.com)

7<sup>th</sup> January 2014

Our ref: FOI RFI 002807

Your ref: email received 24<sup>th</sup> December 2013

Dear Cormac

### Freedom of Information Request

Further to your email dated and received by the Trust on 24<sup>th</sup> December 2013, our response to your request is as follows (highlighted in blue):

*Please provide information on what happens to ashes from cremations involving fetal remains, where there is fetal tissue present, from terminations, miscarriages, and stillbirths.*

Namely:

1. In 2012/13...

*a. How many cremations of fetal remains, where there is fetal tissue present, from terminations, miscarriages or stillbirths were arranged by the Trust? (Please provide a breakdown showing how many of these cremations were individual cremations, and how many were group cremations, including the size of each group.)*

37 Individual cremations were arranged by the Trust  
12 Group cremations were arranged by the Trust viz:  
April 2012 – 118 cremated  
May 2012 – 264 cremated  
June 2012 – 136 cremated  
July 2012 – 241 cremated  
August 2012 – 189 cremated  
September 2012 – 155 cremated  
October 2012 – 201 cremated  
November 2012 – 96 cremated  
December 2012 – 208 cremated  
January 2013 – 165 cremated  
February 2013 – 307 cremated  
March 2013 – 150 cremated

*b. What was the total cost of the cremations?*

Total spent on the above £8692

*c. How many sets of ashes arising from these cremations were returned to families?*

This data is not recorded by the Trust.

Department for  
Information Governance,  
Caldicott & SIRO Support  
Weston Park Hospital  
Whitham Road  
Sheffield  
S10 2SJ

Tel: 0114-2265151  
Fax: 0114-2265152  
Email: [foi@sth.nhs.uk](mailto:foi@sth.nhs.uk)

d. For those sets of ashes not returned to families, how many sets of ashes were buried by/for/at the behest of the Trust? (Please describe where the ashes were buried, including location of plots/sites, the numbers of ashes buried in each plot during the year, and the total number of ashes currently known to be buried in each plot.)

This data is not recorded by the Trust.

e. For those sets of ashes not returned to families, how many were scattered by/for/at the behest of the Trust? (Please describe where they were scattered, including location of sites, the numbers of remains scattered at each site during the year, and the total number of remains currently known to be scattered at each site.)

This data is not recorded by the Trust.

f. For those sets of ashes not returned to families, how many were disposed of as waste by/for/at the behest of the Trust? (Please describe where/how they were disposed, the numbers of sets of ashes disposed of at each site during the year, and the total number of sets of ashes currently known to be disposed at each site.)

This data is not recorded by the Trust.

2. Please provide the same information for the questions above for the year **2011/12**.

a. How many cremations of fetal remains, where there is fetal tissue present, from terminations, miscarriages or stillbirths were arranged by the Trust? (Please provide a breakdown showing how many of these cremations were individual cremations, and how many were group cremations, including the size of each group.)

53 Individual cremations were arranged by the Trust  
12 Group cremations were arranged by the Trust viz:  
April 2011 – 215 cremated  
May 2011 – 254 cremated  
June 2011 – 257 cremated  
July 2011 – 302 cremated  
August 2011 – 78 cremated  
September 2011 – 162 cremated  
October 2011 – 106 cremated  
November 2011 – 275 cremated  
December 2011 – 119 cremated  
January 2012 – 221 cremated  
February 2012 – 273 cremated  
March 2012 – 157 cremated

b. What was the total cost of the cremations?

---

Total spent on the above £8598

c. How many sets of ashes arising from these cremations were returned to families?

This data is not recorded by the Trust.

d. For those sets of ashes not returned to families, how many sets of ashes were buried by/for/at the behest of the Trust? (Please describe where the ashes were buried, including location of plots/sites, the numbers of ashes buried in each plot during the year, and the total number of ashes currently known to be buried in each plot.)

This data is not recorded by the Trust.

e. For those sets of ashes not returned to families, how many were scattered by/for/at the behest of the Trust? (Please describe where they were scattered, including location of sites, the numbers of remains scattered at each site during the year, and the total number of remains currently known to be scattered at each site.)

This data is not recorded by the Trust.

f. For those sets of ashes not returned to families, how many were disposed of as waste by/for/at the behest of the Trust? (Please describe where/how they were disposed, the numbers of sets of ashes disposed of at each site during the year, and the total number of sets of ashes currently known to be disposed at each site.)

This data is not recorded by the Trust.

This completes the Trust response to your request, but please note:

#### **Your rights**

If you are unhappy with the way we have handled your request, you may ask for an internal review in accordance with Section VI Complaints Procedures of the Section 45 Code of Practice of the Freedom of Information Act 2000: and in accordance with Appendix E of the Trust's Code of Practice for Responding to Requests for Information (v 3.0 dated 22/11/11).

If you wish to complain you should contact:

Peter Wilson  
Information Governance, Caldicott & SIRO Support Manager  
Department for Information Governance, Caldicott & SIRO Support  
Sheffield Teaching Hospitals NHS Foundation Trust  
Weston Park Hospital  
Whitham Road  
Sheffield S10 2SJ

Tel: 0114 226 5151  
Fax: 0114 226 5152  
Email: [foi@sth.nhs.uk](mailto:foi@sth.nhs.uk)

If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision.

The Information Commissioner can be contacted at:

Information Commissioner's Office  
Wycliffe House  
Water Lane  
Wilmslow  
Cheshire  
SK9 5AF

If you have any queries about this letter, please contact me. Please remember to quote the reference number above in any future communications

Yours sincerely



Amy Morton  
Information Governance Officer

Ref No: 130203

Dear Mr Basnett,

Thank you for your email of 12 September 2013 where you requested information about the disposal of fetal remains from The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH).

The information you requested is below with answers provided in **bold, blue text**:

in 2011/12 and 2012/13:

1. How many fetuses/fetal remains from miscarriages, stillbirths and abortions were disposed of by the hospital (please only include situations where fetal matter was present)?

2011: 126

2012: 338

2013: 187 (to 12/09/13)

2. Please provide a breakdown by method of disposal. I have provided some examples of categories but you may have others in addition. I am mainly interested in understanding numbers of fetal remains incinerated in groups or with waste, or buried and cremated in groups.

My category suggestions are:

- cremated individually

2011: 1

2012: 0

2013: 0 (to 12/09/13)

- cremated in groups

2011: Two groups of 64 and 61 respectively

2012: Two groups of 124 and 214 respectively

2013: Three groups of 52, 70 and 65 respectively (to 12/09/13)

FOIA(b)(7)(C)

- passed to families for their own arrangements

2011: 0

2012: 1

2013: 0 (to 12/09/13)

FOIA(b)(7)(C)

- incinerated with clinical waste

Nil for all years

- incinerated in groups

Nil for all years

- incinerated individually

Nil for all years

- buried individually

Nil for all years

- buried in groups

Nil for all years

~~3. For those incinerated individually, incinerated in groups, or incinerated as clinical waste, please provide a list of locations where this was carried out. I only want to know the location or location where this happens, so there may only be one, or a few sites.~~

No fetuses/fetal remains were incinerated. All cremations took place at the Bournemouth Crematorium with the service being conducted by the Hospital Chaplaincy.

Please help us to improve our FOI service by completing a short [questionnaire](#).

The information supplied to you continues to be protected by copyright. You are free to use it for your own purposes, including for private study and non-commercial research, and for any other purpose authorised by an exception in current copyright law. Documents (except photographs) can be also used in the UK without requiring permission for the purposes of news reporting. Any other reuse, for example commercial publication, would require the permission of the copyright holder.

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to:

Information Governance Manager

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Castle Lane East

Bournemouth

BH7 7DW

Please remember to quote the reference number above in any future communications.

If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at:

Information Commissioner's Office

Wycliffe House

Water Lane

Wilmslow

Cheshire

SK9 5AF

Yours sincerely

**Freedom of Information Team**

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

[freedomofinformation@rbch.nhs.uk](mailto:freedomofinformation@rbch.nhs.uk)

Our ref: HS/AN/13.487

**Heather Schultz**  
**Freedom of Information Officer**  
East and North Hertfordshire NHS Trust  
Coreys Mill Lane  
Stevenage  
Hertfordshire  
SG1 4AB

27 January 2014

Telephone 01438 285934  
Lister ext. 5934  
Fax 01438 781281  
Email: heather.schultz@nhs.net

Dear Mr Jennings

**Freedom of Information Request – 13.487**

I write regarding your request for information under the Freedom of Information Act, and respond as follows:-

**a. How many foetal remains (where foetal tissue was present) resulting from terminations under 12 weeks of gestation were**

**i) incinerated**

**2012/2013: Total was 427. We can only provide information on foetal tissue under 24 weeks.**

**2011/2012 Total was 320. We can only provide information on foetal tissue under 24**

**ii) buried in groups (please provide breakdown to give size of each group, and location of burial)**

**Not applicable – we do not arrange group burials**

**iii) buried individually**

**The Trust arranged for 7 individual burials in 2012 /2013. There were 9 in 2011 / 2012. We can only provide information on foetal tissue under 24 weeks**

**iv) cremated in groups (please provide breakdown to give size of each group, and location of cremation)**

**We can only provide information on foetal tissue under 24 weeks**

**Group cremations take place at Hendon. 4 x groups over the year consisting of:**

**1 x group of 86 in March 2011  
1 x group of 68 in June 2011  
1x group of 101 in September 2011  
1x group of 40 in November 2011**

**1x group of 120 in May 2012  
1x group of 57 in July 2012  
1x group of 69 in September 2012  
1x group of 15 in October 2012  
1x group of 49 in December 2012**

**1 x group of 89 in Feb 2013  
1 x group of 95 in May 2013  
1 x group of 87 in Aug 2013**

1 x group of 107 in Dec 2013

v) cremated individually

2012/2013: 49 cases in total.

2011/2012 there were 29.

We can only provide information on foetal tissue under 24 weeks.

vi) given to family to make own arrangements

2012/2013: Total of 9 cases

2011/2012: Total of 10 cases.

We can only provide information on foetal tissue under 24 weeks

b. How many foetal remains (where foetal tissue was present) resulting from terminations between 12 and 24 weeks of gestation were

i) incinerated

ii) buried in groups (please provide breakdown to give size of each group, and location of burial)

iii) buried individually

iv) cremated in groups (please provide breakdown to give size of each group, and location of cremation)

v) cremated individually

vi) given to family to make own arrangements

WE ARE UNABLE TO PROVIDE THIS INFORMATION AS THE DOCUMENTATION WE RECEIVE FOR EACH CASE DOES NOT SPECIFY WHETHER TERMINATION / MISCARRIAGE

c. How many foetal remains (where foetal tissue was present) resulting from miscarriages under 12 weeks of gestation were

i) incinerated

ii) buried in groups (please provide breakdown to give size of each group, and location of burial)

iii) buried individually

iv) cremated in groups (please provide breakdown to give size of each group, and location of cremation)

v) cremated individually

vi) given to family to make own arrangements

WE ARE UNABLE TO PROVIDE THIS INFORMATION AS THE DOCUMENTATION WE RECEIVE FOR EACH CASE DOES NOT SPECIFY WHETHER TERMINATION / MISCARRIAGE

d. How many foetal remains (where foetal tissue was present) resulting from miscarriages between 12 and 24 weeks of gestation were

i) incinerated

ii) buried in groups (please provide breakdown to give size of each group, and location of burial)

iii) buried individually

iv) cremated in groups (please provide breakdown to give size of each group, and location of cremation)

v) cremated individually

vi) given to family to make own arrangements

WE ARE UNABLE TO PROVIDE THIS INFORMATION AS THE DOCUMENTATION WE RECEIVE FOR EACH CASE DOES NOT SPECIFY WHETHER TERMINATION / MISCARRIAGE

e. How many foetal remains (where foetal tissue was present) resulting from stillbirths (over 24 weeks of gestation) were

i) incinerated

35 cases in total in 2012/2013. There were 19 cases in 2011/2012.

**ii) buried in groups (please provide breakdown to give size of each group, and location of burial)**

**Not applicable – we do not arrange group burials**

**iii) buried individually**

**7 cases in 2012/2013. 9 cases in 2011/2012**

**iv) cremated in groups (please provide breakdown to give size of each group, and location of cremation)**

**We do not cremate in groups when the foetus is over 24 weeks' gestation**

**v) cremated individually**

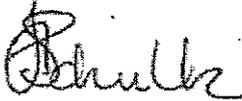
**10 cases in 2012/2013. 35 cases in 2011/2012**

**vi) given to family to make own arrangements**

**15 cases in total in 2012/2013. 15 cases in 2011/2012**

If you are dissatisfied with the way in which your request has been handled please contact me, in the first instance. Ultimately, of course, you have the right of appeal to the Information Commissioner.

Yours sincerely



Heather Schultz  
Freedom of Information Officer

Dear Requester,

It has come to our attention the figures we provided you in September 2013 in response to this request were not entirely accurate. This was due to human error.

Please see attached the correct information.

If you have any queries, please do not hesitate to contact us.

We hope you find this useful and please accept our apologies for any inconvenience caused.

Many thanks,

*Sarah Preston*

Information Governance Team (NO38)

Email: [information.access@ipswichhospital.nhs.uk](mailto:information.access@ipswichhospital.nhs.uk)

Ipswich Hospital NHS Trust

Heath Road, Ipswich, Suffolk IP4 5PD

Tel: 01473 712233

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## MONTHLY COMMUNAL BABY CREMATIONS carried out at Ipswich Crematorium

### April 2011 to March 2012 Communal cremation services

Product of Conception = POC  
Non-Viable Fetuses = NVFs

Month	POC (Under 13 weeks)	NVF's (over 13 weeks)
April 2011	75	11
May 2011	70	1
June 2011	82	None
July 2011	85	5
August 2011	92	2
September 2011	81	6
October 2011	93	7
November 2011	79	3
December 2011	64	3
January 2012	94	6
February 2012	105	3
March 2012	71	5

### April 2012 to March 2013 Communal Cremation services

Month	POC (Under 13 weeks)	NVFs (over 13 Weeks)
April 2012	100	8
May 2012	54	7
June 2012	67	7
July 2012	64	3
August 2012	80	2
September 2012	64	3
October 2012	56	6
November 2012	79	4
December 2012	75	3
January 2013	71	3
February 2013	99	6
March 2013	75	2

## **HOSPITAL ARRANGED INIDIVIDUAL BABY FUNERALS**

### **CREMATIONS HELD AT IPSWICH CREMATORIUM**

### **BURIALS IN BABY AREA OF PUBLIC GRAVE AREA AT IPSWICH OLD CEMETERY**

#### **April 2011 to March 2012**

Fetal remains 13 to 24 weeks (also including stillborn)

Cremation – 23

Burial - 37

#### **April 2012 to March 2013**

Fetal remains 13 to 24 weeks (also including stillborn)

Cremation - 24

Burial - 25

## **PRIVATE FUNERALS ARRANGED BY FAMILIES**

#### **April 2011 to March 2012 :-**

22 – (data includes under 13 weeks, 13 to 24 weeks and stillborn)

#### **April 2012 to March 2013:-**

15 – (data includes under 13 weeks, 13 to 24 weeks and stillborn)

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