

Guidance on the disposal of pregnancy remains following pregnancy loss or termination

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GUIDANCE ON THE DISPOSAL OF PREGNANCY REMAINS FOLLOWING PREGNANCY LOSS OR TERMINATION

Introduction

1. This guidance should inform policies and procedures governing the disposal of pregnancy remains resulting from pregnancy loss or termination of pregnancy in a clinical setting, including NHS and independent hospitals and abortion clinics. It is the result of consultation with key stakeholder groups (see Appendix 1). The geographical extent of the guidance is England, Wales and Northern Ireland.
2. The term 'pregnancy remains' is used throughout in relation to all pregnancy losses, for example as a result of ectopic pregnancy, miscarriage or early intrauterine fetal death; it also applies to terminations of pregnancy that have not exceeded the 24th week of pregnancy¹.
3. The guidance does not apply to stillbirths (babies born dead after the 24th week of pregnancy) and neonatal deaths (see paragraphs 34-37). Nor does it apply to the disposal of embryos created in vitro (for fertility treatment or embryo research); these are regulated by the Human Fertilisation and Embryology Authority (HFEA).
4. The Human Tissue Act 2004 (HT Act) makes no distinction between the disposal of pregnancy remains and the disposal of other tissue from a living person; pregnancy remains are regarded as the tissue of the woman. Although under the HT Act, consent is not required for the disposal of pregnancy remains, the particularly sensitive nature of this tissue means that the wishes of the woman², and her understanding of the disposal options open to her, are of paramount importance and should be respected and acted upon.
5. The guidance sets out the minimum standard expected for the disposal of tissue following pregnancy loss or termination of pregnancy, which is: cremation, burial or incineration in certain circumstances. Incineration should only occur where the woman makes this choice, or does not want to be involved in the decision, or does not express an opinion within the stated timescale (see para 19), and the hospital

¹ As specified in section 1(1)(a) of the Abortion Act 1967. Late terminations that exceed 24 weeks gestation are subject to the requirements of the Birth and Deaths Registration Act 1953, and must be registered as stillbirths.

² Throughout the guidance, we refer to 'the woman'; however, it should be taken into account that a woman may choose to delegate the decision to her partner, a family member or friend.

considers this to be the most appropriate method of disposal. Hospitals that currently do not offer incineration as an option and cremate or bury all pregnancy remains as a matter of routine, should consider whether their policy limits the options given to women and how they would respond should a woman's preference be for her pregnancy remains to be incinerated.

6. The guidance applies equally to NHS hospitals and independent sector providers.
7. Guidance on the disposal of pregnancy remains is also available from the Royal College of Nursing:
http://www.rcn.org.uk/_data/assets/pdf_file/0020/78500/001248.pdf

The importance of communication and information

8. In all cases, the woman should be made aware that there are options for disposal. She should be given verbal or written information about the options, given the opportunity to discuss them, and supported in an individual and sensitive manner to ensure that she can make a decision that is right for her.
9. The information provided should include an explanation of how the pregnancy remains will be disposed of if the woman does not wish to make a decision and would prefer the hospital to handle the matter. It should also explain who to contact to request a particular disposal option and the timescale for this. Personal, religious or cultural needs relating to the disposal of the pregnancy remains should be met wherever possible. For example, in Islamic teaching, all pregnancy remains must be buried.
10. Some women may not wish to know about the disposal of the pregnancy remains or be involved in decisions about disposal, and may decline the offer of information about the possible options. Providing they have been told that the information is available, establishments should recognise and respect the wishes of those women who choose not to engage in the matter of disposal.
11. Whatever she decides, including whether she declined the offer of information and chose not to be involved in the decision, should be recorded in the woman's medical notes.
12. The loss or termination of a pregnancy, whatever the circumstances, is clearly an exceptionally sensitive and emotional time for a woman. Policies and procedures need to acknowledge and make provision for the fact that, whilst a woman may not wish to engage in discussions about disposal of pregnancy remains (or make a

decision), she may change her mind at a later date or ask about what arrangements were made. It is therefore important to ensure that as well as respecting the wishes of those who choose not to be involved at the time, the disposal of pregnancy remains is carried out as outlined within this guidance.

13. Detailed guidance on communication with women regarding pregnancy loss may be found in guidance from the Stillbirth and neonatal death charity (Sands) [<https://uk-sands.org/resources>].

Developing a disposal policy

14. Hospitals' disposal policies should ensure that pregnancy remains are treated with respect regardless of the circumstances of the loss or termination, and that women are aware that there are disposal options available to them.
15. It is essential that guidance and practice on disposal reflect the sensitivity required when dealing with pregnancy remains. The needs of the woman are of paramount importance in the development of a disposal policy, which should be written in such a way as to make it suitable for women who choose to access it.
16. All staff who may be asked, or expected, to provide information about disposal should be aware of the policy and prepared to discuss it. They should be sensitive to the values and beliefs of a wide range of cultures and religions, particularly those of their local community, whilst at all times remembering that each decision is particular to the individual woman. The staff involved with these discussions should have detailed knowledge of, and understand the practical aspects of, each form of disposal to be able to properly communicate this information to the woman. This might include the likelihood of recovering remains following a cremation, or perhaps the opportunity for some form of memorialisation if burial is chosen.
17. There should be training for staff to equip them to best support the woman in a sensitive and caring manner. Because of the very sensitive nature of the disposal of pregnancy remains, all staff should have access to education about the process and be reminded about access to counselling services should they feel the need for support themselves.
18. The policy and supporting procedures should ensure that disposal of pregnancy remains in line with the woman's wishes take place as soon as practicable after she has communicated her decision.

19. Where the woman has not made a decision about disposal within a locally specified period of time since the pregnancy loss or termination (which should not exceed 12 weeks), the hospital responsible for the woman's care should make arrangements for disposal in line with this guidance. The woman should be made aware of the time period when first given information about disposal options.
20. Records of how and when the remains were disposed of, including, where relevant, the name of the cemetery or crematorium, should be maintained by the hospital in order that full information may be provided at a later date if requested.

Disposal options

21. Cremation and burial should always be available options for the disposal of pregnancy remains, *regardless of whether or not there is discernible fetal tissue*. Sensitive incineration, separate from clinical waste, may be used where the woman makes this choice or does not want to be involved in the decision and the establishment considers this the most appropriate method of disposal.

Cremation

22. Although not covered by The Cremation (England and Wales) Regulations 2008, pregnancy remains may be cremated and most crematoria are willing to provide this service. Establishments will need to negotiate with the local crematoria to agree the level of service to be provided. If this service is not available locally, they should consider negotiating with other service providers further afield. The ICCM's policy and guidance 'The Sensitive Disposal of Fetal Remains' contains a draft agreement which may be helpful to establishments [<http://www.iccm-uk.com/iccm/index.php>].
23. If the establishment is not able to access the services of a crematorium, they should explain to the woman that they will not be able to arrange for the pregnancy remains to be cremated and give her the opportunity to make her own arrangements or identify a crematorium to which the remains may be sent on her behalf.
24. Where the pregnancy remains will be cremated alongside others, the woman should be informed and, if necessary, made aware of what alternative options exist. As a minimum, the remains should be in individual sealed containers, collected together into a larger sealed container. In order to maintain an audit trail, in any communications with the crematorium about shared cremation, hospitals should identify each set of pregnancy remains with either the woman's name or a

unique reference/case number if confidentiality needs to be maintained. Patient details should not be shared without the express permission of the woman.

25. When discussing the option of cremation of pregnancy remains, women should be told that ashes may not always be recovered in the case of an individual cremation. Sands has produced guidance on this topic, which can be accessed via their website.

Burial

26. Pregnancy remains may also be buried. Establishments should consult the local burial authorities to establish what level of service is available and if the service is not available locally, they should consider contacting other service providers further afield.
27. Where the pregnancy remains will be buried in the same plot as other sets of remains, the woman should be informed and, if necessary, made aware of what alternative options exist. As a minimum, the remains should be in individual sealed coffins or containers, collected together into a larger sealed container. In order to maintain an audit trail, in any communications with burial authorities about shared burial, hospitals should identify each set of pregnancy remains with either the woman's name or a unique reference/case number if confidentiality needs to be maintained. Patient details should not be shared without the express permission of the woman.
28. When discussing the option of shared burial, the woman should be told that there will be no individual memorialisation available to mark the location of the burial.

Sensitive Incineration

29. Incineration may be used where the woman makes this choice or does not want to be involved in the decision, preferring to leave it to the hospital to make arrangements, or does not make a decision within the stated timescale and the hospital has made a considered decision that this is the most appropriate method of disposal.
30. Although incineration and cremation both involve the pregnancy remains being burnt, they are not the same. It is important that the woman understands what is meant by incineration and the distinction between this and cremation, in order that she can make an informed choice. The staff involved with communicating the

information to the woman should have detailed knowledge of the processes to ensure that they are able to properly explain this information.

31. Pregnancy remains should be subject to a different process from clinical waste. They should be packaged and stored separately in suitable containers prior to their disposal, and incinerated separately from clinical waste. Establishments may wish to consider optional additional arrangements they could make to dispose of the tissue sensitively, for example by involving their hospital chaplain or local spiritual leaders. However, the woman's wishes are paramount and where a woman has opted for incineration precisely because she does not wish her pregnancy remains to be given any special status, this should be respected.
32. Where incineration is the disposal method used, it must be done as sensitively as possible. The date of the collection and the location of the incineration should be recorded.

Returning the pregnancy remains to the woman

33. Some women may wish to make their own arrangements for the disposal of their pregnancy remains. It is appropriate in these cases for the hospital to offer advice and assistance, although any costs incurred will normally be the responsibility of the woman. If the woman requests that the remains be returned to her, they should be stored in an appropriate container in a safe place and made available for collection by the woman or her representative. The decision, and the date of collection, should be recorded in the woman's medical notes and she should be given written confirmation that she is entitled to take the remains to make her own arrangements.

Stillbirths and neonatal deaths

34. Babies born dead after the 24th week of pregnancy are defined in law as stillbirths and must be registered as such. This includes late terminations that take place at gestations exceeding 24 weeks. Common law requires that stillborn babies must be buried or cremated.
35. 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. The law requires that where a baby or fetus is born showing signs of life and then dies, their birth must be registered and they must be buried or cremated.

36. While the legal duty to make funeral arrangements following 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 towards burial or cremation. If parents would like this, they should be given the opportunity to attend the ceremony.
37. 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/>].

Appendix 1

The following organisations were consulted in the development of this guidance:

Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Midwives
British Pregnancy Advisory Service
Stillbirth and Neonatal Death Charity (Sands)
Miscarriage Association
Institute of Cemetery and Crematorium Management (ICCM)
The Federation of Burial and Cremation Authorities (FBCA)
Care Quality Commission
Department of Health
Ministry of Justice

Frequently asked questions

A set of FAQs which provide more practical information on implementing this guidance are available on the HTA website:

<https://www.hta.gov.uk/faqs/disposal-of-pregnancy-remains-faqs>