Promoting · Supporting · Influencing

640/15

Angus West

27 MAY 2016

26 May 2016

Mr David Hinchliff
Senior Coroner
West Yorkshire (Eastern)
Coroner's Office and Court
71 Northgate
Wakefield WF1 3BS

Dear Mr Hinchliffe,

Thank you for your letter of 25 April 2016, and I do apologise for the delay in replying.

I have taken the opportunity to seek the views of the RCM Advisory Forum as they are very helpful with strategic issues and of course they all practice within the context of contemporary midwifery practice. My response is therefore based on this information and my own experience of best practice across the UK. For information purposes the forum is comprised of midwives, students and maternity support workers who are clinically working within maternity services across the UK.

Given the view of the RCM Advisory forum and what I believe to be best practice, I entirely agree with your recommendations to this particular NHS Trust. I would have expected that for any baby compromised in labour or requiring transfer to the Neonatal Unit the advice would be to have the placenta retained and safely stored and therefore available should there be a demise in the baby and a need for a post mortem examination at a future point in time.

For further information I have included below information regarding current practice, disposal and reasons to store placenta within the NHS as it stands today.

Current placental disposal following the majority of births is as follows

All placentas are disposed of post- delivery by sealing them in a sharps guard anatomical plastic bag and transferred into a permanently sealed plastic pot for incineration following examination by the midwife or clinician post birth.

Exceptions to the above: retaining the placenta for pathology purposes

Stillbirth
Late fetal loss
Significant fetal compromise in labour
Baby with a low Apgar score
Baby transferred to Neonatal Unit
Baby who has had extensive resuscitation
Baby with abnormalities
Prematurity

Some maternity units keep and examine placenta in the following cases

Intra uterine growth restriction i.e. birthweight below the 3rd centile
Placental abruption
Rhesus isoimmunisation
Morbidly adherent placenta
Multiple births
Abnormal placental shape
Two vessel cord
Prolonged rupture of membranes >36 hours
Maternal group B streptococcus
Pre eclampsia/maternal hypertension
Maternal substance misuse
Gestational diabetes
Maternal coagulopathy

In addition it is worth noting that some women do take care of their own placenta by taking them home from the maternity unit or birth centre. On a final note one of the biggest challenges within maternity care is safe storage of placenta should we hold large numbers in case of neonatal deterioration.

I do hope this information is helpful but please do contact me if you require any further information.

Yours sincerely,

Professor Cathy Warwick, CBE
Chief Executive