Frimley Health NHS
NHS Foundation Trust

Babies born at the threshold of viability

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1. Introduction

Delivery at the threshold of viability (23^{+0} weeks to 24^{+6}) is a major medical and ethical challenge. It should be preceded by the best possible advice from a multidisciplinary neonatal and obstetric team, which informs the parents fully, seeks to achieve a consensus on the best way forward and provides the best care for the mother and neonate.[1]

2. The law and its interpretation

If a baby is born alive, regardless of its gestational age or its normality, it has legal rights and consequently, a right to life. *Article 2* of the *European Convention on Human Rights* enshrines this right to life stating that '*No one shall be deprived of life intentionally*'. The *1998 Human Rights Act* incorporates this into UK law. However, if it is apparent that, regardless of any therapeutic measures the baby is likely to die shortly, this must also be taken into account. The definition of 'born alive' has an important bearing.

The World Health Organization (WHO) has issued the following definition: [6]

> '*a live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or any definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached'* (WHO, 1992).

Despite the fact that 24 weeks gestation is the legal age of viability, if a baby were born alive at less than this gestation and the nurse, midwife or doctor in attendance did not take steps to resuscitate the baby, they or their employer could be seen to be in breach of *Article 2*. They could be deemed to be negligent and could even be accused of manslaughter or murder. **Detailed guidance according to gestation is given on page 4.** This would not be so in the case of an extremely preterm baby (below 22 weeks); if the baby had a severe congenital anomaly (such as anencephaly) or if the parents had previously agreed that resuscitation was not in the baby's best interest. In such cases, the British Association of Perinatal Medicine advises 'comfort care' such as being wrapped and cuddled, given oral nourishment and treated with dignity, respect and love.[2]

3. The decision to initiate intensive care

If an extremely pre-term birth is anticipated, the parents should be counselled by the senior obstetric and neonatal team regarding the possible outcomes for the baby. A clear plan of care should be agreed and documented. An experienced obstetrician (usually a consultant) and an experienced paediatrician (usually a consultant) should be informed as soon as possible so that the best advice is available for each individual case.

The obstetric and antenatal history should be considered, in particular the antenatal dating ultrasound scan.

Discussion with parents must include information about the expected outcome, the practicalities of starting, withholding or withdrawing care and the positive role of palliative care.

Consideration of transfer to another hospital for higher level neonatal care should be discussed if it is clinically appropriate.

In utero transfer

If the decision is made to initiate intensive care at the birth, arrangements should be made for an in-utero transfer to a unit with a neonatal intensive care unit (NICU) whenever possible. Diagnosis of preterm labour can be challenging. Refer to the guideline for preterm labour.

4. Preparing for birth

When the birth is imminent and will inevitably take place, an experienced paediatrician should be present at the birth to make a confirmatory assessment of the gestational age and condition of the baby.

If active resuscitation is planned at birth the fetal heart should be monitored via intermittent auscultation to inform neonatal rather than obstetric management.

5. Resuscitation at birth

Preterm labour often progresses rapidly and there may be no time to hold a detailed discussion with the parents prior to birth. A decision about resuscitation should be made on the basis of the most recent clinical information. Lung inflation with an appropriate sized mask should be carried out as per the unit's policy 'Newborn life support'.

The Royal College of Paediatrics and Child Health (RCPCH) [3] recommends:

If a baby is born alive but there has been no opportunity to agree a management plan and a neonatologist is not immediately available, the health care professional should use his/her professional judgement as to whether or not the baby is capable of survival. Resuscitation should begin straight away if it is likely that the baby could survive for more than a short period of time.

Where gestational age is confirmed the following should be considered in deciding whether or not to initiate care: [4]

- **Below 22 weeks of gestation,** no baby should be resuscitated
- **Less than 22^{+6} weeks gestation.** Standard practice is not to resuscitate a baby. If the parents wish they should have the opportunity to discuss outcomes with a second member of the perinatal team. Survival and discharge from NICUs at this gestation is rare.
- **Between 23^{+0} and 23^{+6},** if the fetal heart is heard during labour a professional skilled in resuscitation should be available to attend the birth. Not to start resuscitation is deemed to be an appropriate approach if resuscitation is judged to be futile. If resuscitation is commenced the response of the heart rate will be critical in deciding whether to continue resuscitation.
- **Between 24^{+0} and 24^{+6}:** full invasive intensive care and support from birth should be initiated unless the parents and clinicians agree the baby will be born extremely compromised and it is not in his/her best interests to start intensive care.
- When a baby is born alive at **25 weeks or more** intensive treatment should be initiated unless he/she is known to be affected by some severe abnormality incompatible with any significant period of survival.
- **Uncertain gestational age:** If gestational age is uncertain an ultrasound scan by an experience sonographer can be carried out if time permits. If the fetal heart is heard during labour a professional skilled in resuscitation should be available to attend the birth. The decision can then be made, in the best interests of the baby as to whether to begin mask ventilation. The response of the heart rate will be crucial in judging the appropriateness of continuing resuscitation. Senior staff should be called if there are any concerns about the decision.

6. Immediate management

- Call for help – if the paediatric team is not in attendance, a 'neonatal emergency' call should be initiated via 2222. A neonatal nurse should also be asked to attend with the usual additional equipment in the neonatal emergency bag/trolley.

- At birth, the pre-term baby should be placed (still wet) up to its neck in a polythene bag to maintain its body temperature.
- The baby should be transferred to a resuscitaire for immediate treatment (see Neonatal Resuscitation guideline). The baby will be transferred to SCBU/NNU as soon as possible.
- Arrangements to transfer the baby to a NICU should be initiated at the earliest opportunity via the Emergency Bed Service (see guideline on ex-utero transfer).

7. Birth notification/registration

- If the baby is born alive, notification of birth should be submitted in the usual way. The parents should be advised that they must also register the birth.
- If the baby later dies, the parents will also have to register the baby's death.
- If the baby is born at 22 weeks of gestation or above or weighed 400g or more, the birth must be notified using the appropriate form via the labour ward manager (FPH) or the patient safety midwife (WPH). This is regardless of whether or not the baby was born alive.[2]
- If the baby was born at 24 weeks of gestation or above but did not breathe or show any other sign of life, it must be registered as a stillbirth (*Section 41 of the Births and Deaths Registration Act 1953* as amended by the *Stillbirth Definition Act 1992*). See below for clarification.
- When a fetus is born dead after 24 weeks gestation but it is known that death occurred before 24 weeks of pregnancy elapsed (for example where intra-uterine death was confirmed by ultrasound scan) it would not be registered as a stillbirth. This is in keeping with guidance from the RCOG[8] and RCM[9] with agreement from the Department of Health. A certificate of pregnancy loss may be offered (see example certificate at Appendix 1).
- There are no legal requirements regarding notification or registration of any fetus born at 23^{+6} gestation or less when it did not breathe or show any other sign of life.[8] However, disposal of the fetal remains should be discussed in a sensitive manner with the parents. They should be asked to indicate their preferences for funeral arrangements to the hospital chaplain within four weeks of the delivery (see checklist for late fetal loss). A locally devised certificate for pregnancy loss before 24 weeks gestation may also be signed by the doctor or midwife and given to the parents. This certificate has no standing in law and is offered to the parents as a keepsake (see Appendix 1).

8. Support for the parents/family

No parent would wish to make life and death decisions concerning their own offspring. It is an extremely distressing scenario. Time may be limited and the consequences of the parents' deliberations may remain with them for life. Effective communication is essential. Information is of the essence and should be conveyed clearly, simply and honestly. The parents should be recognised and respected as individuals with a unique set of personal, cultural and religious beliefs. Their beliefs will inform their thinking. Additional support should be offered as appropriate. This may include pastoral or social support.

9. Support for health care professionals

Regardless of previous experience, decisions concerning the initiation of neonatal resuscitation can be extremely stressful and upsetting for staff. Midwives have access to a supervisor of midwives who can be contacted for advice and/or support at any time. Medical, nursing and support staff should approach their senior colleagues for help. The hospital chaplaincy service is available for pastoral and spiritual support. A staff counsellor is also available by appointment through occupational health.

10. Communication

If there are communication issues (e.g., English as a second language, learning difficulties, blindness/partial sightedness, and/or deafness) staff will take appropriate measures to ensure the patient (and her partner, if appropriate) understand the actions and rationale behind them.

11. Auditable standards

All cases will be reviewed through the risk management process.

12. References

1. Royal College of Obstetricians and Gynaecologists (2014)
2. Garel M, Seguret S, Kaminski M, Cuttini M (2004). Ethical decision making for extremely preterm deliveries: results of a qualitative study among obstetricians and midwives. *The Journal of Maternal-Fetal and Neonatal Medicine*:15(6), 394-9.
3. British Association of Perinatal Medicine. (2008) *The management of babies born extremely preterm at less than 26 weeks of gestation*: *A framework for clinical practice at the time of birth.* London. BAPM.
4. Royal College of Paediatrics and Child Health (2004). 2nd edition *Withholding or withdrawing life sustaining treatment in children: a framework for practice.* London: RCPCH.
5. Nuffield Council on Bioethics (2006). Critical care decisions in fetal and neonatal medicine: ethical issues. London: NCoB.
6. Nursing and Midwifery Council. *The care of babies born alive at the threshold of viability.* 03/NMC circular, 15th January 2007.
7. World Health Organization (1992). International statistical classification of diseases and related health problems (tenth edition). Geneva: WHO.
8. Haumont D (2005). Management of the neonate at the limits of viability *British Journal of Obstetrics and Gynaecology*:11 (s1), 64–6.
9. Royal College of Obstetricians and Gynaecologists (2005). Good Practice No. 4. *Registration of stillbirths and certification for pregnancy loss before 24 weeks of gestation.* London: RCOG
10. Royal College of Midwives (2005). Guidance Paper No. 2. *Registration of stillbirths and certification for pregnancy loss before 24 weeks of gestation.* London: RCM. http://www.rcm.org.uk/midwives/features/registration-of-stillbirths-and-certification-for-pregnancy-loss-before-24-weeks-gestation/?locale=en (last accessed 15/09/2016)

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Appendix 1

Certificate of Pregnancy Loss

This is to certify that _____

Was born to:
(mother) _____

and

(father) _____

at _____

on _____

after _____**weeks of gestation**

and showed no signs of life

Signed _____

Name _____

Registered qualifications _____

Date _____