Cooling a Baby's Body After Perinatal Death

A Resolve Through Sharing Position Statement

Gundersen Medical Foundation
www.ResolveThroughSharing.org

Resolve Through Sharing. (2019, 2025). *Cooling a baby's body after perinatal death: A Resolve Through Sharing position statement.* La Crosse, WI: Gundersen Lutheran Medical Foundation, Inc.

The Pregnancy Loss and Infant Death Alliance (PLIDA) endorses this position statement (www.plida.org).

Resolve Through Sharing®
BEREAVEMENT EDUCATION SINCE 1981

Introduction

Since its inception in 1981, Resolve Through Sharing (RTS) has made providing relationship-based and evidence-based care to grieving families its primary mission. RTS promotes unrestricted parent and family contact with their babies who have died before or shortly after birth.

This position statement refers to a recent, untested development in care of families—cooling a baby's body after death. Some assert a deceased baby's body should be cooled to allow for optimal contact with loved ones in the hospital setting. Some have linked the length of time a baby can remain with their family to availability of a cooling system. *Neither of these beliefs is true.*

Family-centered bereavement care is dependent on relationship, not equipment. Research has shown that what parents remember most are a) moments together with their baby and b) behaviors and actions of healthcare professionals—whether they are positive or negative.

RTS firmly holds the position that parents should be given a choice in every aspect of their grief experience, a position supported by research and experts. Although there is no evidence supporting the idea that cooling allows for more time with a baby, some parents desire it. For this reason, cooling should be offered as an option. As authorities in the deterioration of a body after death, it is the caregiver's responsibility to help parents navigate this unimaginable territory from an evidence-based perspective.

This statement defines and explains cooling. Herein, Resolve Through Sharing experts encourage clinicians to support parents' unrestricted time to hold and be with their babies—with or without a cooling method.

Key Questions

- Do effective cooling options exist in a hospital?
  Yes
- During the postpartum hospital stay, will cooling reverse or noticeably slow postmortem bodily changes?
  No
- Does a deceased baby need to be cooled in order to stay in the patient's hospital room for an extended period of time?
  Almost never
- When does a deceased baby's body need to be cooled?
  If the baby will be a tissue donor
- Should parents be offered the option to cool their deceased baby?
  Yes
- Do healthcare organizations have a responsibility to ensure evidence-based cooling practice standards?
  Yes

Do effective cooling options exist in a hospital?

Significant cooling options are available in hospital settings. In this position statement, *significant cooling* refers to continuous or intermittent cooling at temperatures 42 °F/5.6 °C or below. Significant cooling can be achieved through the use of a dedicated cooling area (e.g., the morgue) or an in-room cooling device used to reduce hypoxic ischemic encephalopathy (i.e., brain swelling in infants). The units are used in the NICU for this condition and are generally available through central supply. They are used in other hospital areas for similar purposes. Their temperatures can be controlled to as low as 39.2 °F/4 °C.

Minor cooling is also available in hospital settings. In this position statement, *minor cooling* refers to continuous or intermittent cooling at temperatures 45 °F/7.2 °C or above. Minor cooling is typically achieved through the use of in-room cooling cold-water circulation blankets. This same technology is used by a number of commercial cooling systems available to bereaved parents.

Using any type of cooling equipment will require adherence to infection control and other hospital code requirements.

During the postpartum hospital stay, will cooling reverse or noticeably slow postmortem bodily changes?

After death, the integrity of a baby's body will change over time. Significant cooling may decrease serous drainage from the nose and slow the production of unpleasant odors; however, cooling will not significantly decrease livor mortis (i.e., discoloration of the skin due to the pooling of blood). There is no current evidence that minor cooling from the use of blanket systems reduces the rate at which postmortem bodily changes occur during typical postpartum hospital stays (12-24 hours).

In the case of a baby who died one day or more before birth, body integrity has already been affected. Skin slippage and changes in organs and bony structures begin

Myths and Facts

Myth: Deceased babies are able to stay in patients' hospital rooms longer when cooling is provided.

Fact: With or without cooling, deceased babies can stay with parents in their rooms for as much time as desired.

Myth: Parents do not receive quality bereavement care if their baby is not cooled.

Fact: Parents can receive quality bereavement care with or without cooling. Beginning in the 1980s, countering pressure to move babies from their parents' hospital rooms to the morgue over unsubstantiated safety and appearance concerns, numerous professionals and parents identified a more relational approach. Despite a baby's death, they advocated for family time and celebration during these devastating moments. Professionals began advancing perinatal bereavement care to a family-centered experience, promoting parents getting to know their baby and becoming comfortable with their baby's temperature, appearance, and features. All these things set a new standard for quality bereavement care that did not require cooling as a part of the protocol when a baby died.

Despite these efforts and advancements, myths about the need for and benefit of cooling a baby's body persist today. Although cooling can be offered as an option, the standard of care is not diminished when it is not chosen.

at death. The exact time of an intrauterine death is usually impossible to determine. Bodily deterioration may be significant at the time of birth, as the baby may have died long before. This deterioration cannot be reversed and will not be noticeably slowed. Healthcare professionals should adequately prepare parents for what they will encounter in these situations.

Does a deceased baby need to be cooled in order to stay in the patient's hospital room for an extended period of time?

A deceased baby does not need to be cooled in order to stay with parents or to be held for an extended amount of time. While hospital stays are usually much shorter, babies have stayed with parents in their rooms for several days without being cooled. Allowing deceased babies to stay with their parents without cooling for the same length of time as a typical postpartum hospital stay has been recognized as a standard of care for decades.

When does a deceased baby's body need to be cooled?

Babies who die shortly before birth or during the neonatal period (i.e., within 28 days of birth) may be candidates for tissue donation. For this to occur, documented last known time of fetal heart tones is required, the body must be significantly cooled, and the recovery of tissue needs to take place within a specified time frame. Details and logistics should be coordinated with the hospital's contracted tissue recovery agency. Parents should have the opportunity to see and hold their baby after the surgery, if they desire to do so. After the procedure, cooling is no longer necessary to preserve tissue.

If the tissue donation process occurs during the patient's postpartum stay, in-room cooling should be offered.

Should parents be offered the option to cool their deceased baby?

As previously stated, cooling a baby's body is not essential in most cases. However, some parents may feel that

Myths and Facts

Myth: Cooling will improve the appearance of babies who have died.

Fact: Cooling does not reverse or alter deterioration that has already taken place.

Myth: There is an increased risk of contracting disease and infection from contact with a baby's body that is not cooled.

Fact: The delivered baby who has died before birth, no matter the gestation, time of death, or method of delivery, has the same bacterial flora as a baby born alive. After death, the body does not produce new pathogens. Infection risks are insignificant for bereaved parents who have close contact with their deceased baby's body.

There is virtually no risk to the parents or others who wish to hold the baby with one notable exception: If a patient has active genital herpes infection, the baby may also have the virus. If the patient is undergoing treatment or is not experiencing an outbreak, there is no issue. If they are not undergoing treatment or are experiencing an outbreak, proceeding with caution is warranted when visible skin lesions are present on the baby's body. Anyone holding the baby should not make direct contact with the baby's skin where lesions appear. In any case, the baby can still be held with no significant risk. Cooling has no impact on controlling infection in a deceased baby's body.

cooling will improve their brief time with their baby. They may have read or heard that cooling devices make it possible to spend additional time with their baby. Though this is not true, they still may choose it. When cooling is offered to bereaved parents, clinicians should be prepared to provide information on the realities of selecting this option.

When babies' bodies are cooled, the following are likely to occur:

- The way the baby looks when they are born will not change. Postmortem changes present at the time of death will not be reversed or improved.
- The body becomes cold to the touch.
- The body becomes firmer, even stiff at colder temperatures (i.e., temperatures that can be achieved with significant cooling).
- The body will experience dramatic temperature shifts if both holding and cooling the baby are done repeatedly during the brief hospital stay. This cooling and warming of a baby's body may cause more rapid deterioration than forgoing cooling altogether.
- Bodily changes that have occurred prior to death will not be reversed.
- The time the deceased baby can stay in their parent's hospital room will not be extended.

In addition to the realities listed above, another likely ramification is that parents may forego the opportunity to hold their baby in order to prioritize cooling. They may feel pressure to keep the baby on the cooling unit, because they believe any number of myths (e.g., cooling will slow deterioration, cooling will prevent infection, cooling is necessary).

Do healthcare organizations have a responsibility to ensure evidence-based cooling practice standards?

Healthcare organizations have a responsibility to ensure evidence-based cooling practice standards.

The first step is creating policy specifications and/or

Myths and Facts

Myth: The best methods to cool a deceased baby are supplied by commercial cooling companies.

Fact: Every hospital has methods to minimally or significantly cool a deceased baby through the use of designated cooling areas or medical grade equipment, which is usually already available.

Myth: The act of caregiving is not affected by choosing to cool a baby's body.

Fact: Parents who choose cooling may miss opportunities to administer acts of caregiving with their babies. Some may worry that deterioration will accelerate if the baby is not continuously cooled.

When families wish to be involved in acts of caregiving, such as holding, dressing, and bathing, the baby will not spend considerable time in the cooling device.

Myth: When offered cooling, parents will always choose it.

Fact: Some parents do not wish their baby's skin to be cold. Others believe significant cooling will interfere with the natural signals sent by their baby's body. A number of parents have stated that these changes were their babies' way of letting them know when it was time to say goodbye, helping them feel confident in their parenting decisions.

exceptions allowing deceased babies to remain in patient rooms as long as parents desire. If local statutes require cooling of a deceased body after a specific time without exception, the organization should ensure appropriate equipment is available for significant in-room cooling. Hospital-grade cooling options adhere to infection control and other hospital code requirements. Commercial cooling systems designed specifically for babies do not meet this need. Interprofessional team members (e.g., pathologists, laboratory technicians, tissue procurement technicians, certified bereavement coordinators) should advise on policy development.

Policies can ensure organizations are not dependent on donations from bereaved parents to maintain their standards of care. They also help assure equity for marginalized communities where wealthy, philanthropic funding is not available.

No matter what kind of equipment is used, families will not get the care they need and deserve if staff are not prepared to guide them through these difficult events. In keeping with The Joint Commission Standard PC.02.02.13, organizations must ensure staff have adequate bereavement education and resources to support patients and their families at the end of life. When considering perinatal death practices and policies, the most important thing to remember is that clinicians must be comfortable and competent in preparing parents to meet their babies who have died. It is only then parents can feel assured that they received the best care possible.

Myths and Facts

Myth: Parents are afraid to see and hold their babies born still. Healthcare professionals should protect parents from this trauma.

Fact: While some parents decline the opportunity to be with their babies born still, most believe their babies are beautiful and want to spend as much time as possible holding and cuddling them.

Myth: All parents' grief journeys are improved when cooling baskets are provided for babies born still.

Fact: No matter what options are offered, parents cannot take a living baby home. No amount of cooling will change that. The death of a baby will not be made miraculous by a cooling basket; parents still experience intense grief. They feel most supported when they are cared for by competent clinicians and staff and properly prepared for what to expect when their baby dies.

Conclusion

For decades, experts have promoted unrestricted access for bereaved parents to their babies who have died. Well-intentioned but misinformed healthcare professionals have promulgated the need for cooling deceased babies and often prohibited parents from spending time with them. Evidence-based practice has worked hard to dispel this cooling myth, the very reason infants have been taken from their parents for years. Research shows that both parents and staff have identified the need for improved training in this area. Their experiences of stillbirth can inform program development that improves the provision of care. RTS promotes quality education that enhances parental understanding and supports all their choices.

Though cooling is not necessary for parents to have unrestricted contact with their babies who have died, parents may choose cooling for a number of reasons. Healthcare professionals should offer and provide cooling in a way that informs parents from an evidence-based perspective while building a trusted

relationship. It is vital that clinicians support parents' wishes during these devastating situations and honor their choices. Resolve Through Sharing encourages healthcare providers to advocate for parents' unrestricted time with their babies who have died.

Resources

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