Aneurin Bevan University Health Board

Maternal Death Reporting and Investigating Guideline

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Introduction

Maternal deaths are rare events and the following guidelines serve to support staff in ensuring effective management of such situations. Maternal death within the context of this guideline relates to that which occurs during or up to one year after the end of pregnancy.

As you will be aware MBRRACE-UK is the new organisation appointed by the Healthcare Quality Improvement Programme (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths.

MBRRACE are to be notified by designated registered staff (see appendix 4 for process instructions) of all maternal deaths.

All maternal deaths are subject to a serious incident review as per Aneurin Bevan Health board policies.

Scope of guideline

This guideline applies to all clinicians working within maternity services.

Aims

The aim of this guideline is to ensure that all maternal deaths are reported and investigated in a timely manner.

Roles and Responsibilities

It is the responsibility of the designated co-ordinator (usually the attending midwifery manager) to ensure that a number of tasks are completed at the earliest opportunity, and these include:

- Last offices as per Health Board policy
- A discussion with the relatives re: post mortem
- Signing of the consent form for post mortem where agreed
- Ensure the case notes and any attached documentation is photocopied
- Issue of the death certificate when available
- If applicable Stillbirth certificate for baby as per local guidance – contact labour ward
- Advice and information to relatives regarding registering the death

- Complete electronic adverse incident form

Training

- Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical supervision. Training data bases are maintained by the practice educator.

Audit

The guideline will be audited following a maternal death to ensure it is fit for purpose. Results to be shared at the Directorate Clinical Governance Forum

References

Saving Lives improving Mothers care 2015

Appendix 1 - Definitions

Definitions taken from the Saving Lives Improving Mothers Care 2015

Term	Definition
Maternal Death	Deaths of women while pregnant or within 42 days of the end of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.
Direct	Deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above.
Indirect	Deaths resulting from previous existing disease, or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiologic effects of pregnancy.
Late	Deaths occurring between 42 days and 1 year after abortion, miscarriage or delivery that are due to *Direct* or *Indirect* maternal causes.includes giving birth ectopic pregnancy miscarriage or termination of pregnancy
Coincidental	Deaths from unrelated causes which happen to occur in pregnancy or the puerperium.

Appendix 2 - Managing a Maternal Death

- The on call Obstetric Consultant, on call Consultant Anaesthetist and on call Midwifery Manager will agree a person who will maintain the maternal death checklist (Designated Co-ordinator). The attached checklist will guide the
  Co-ordinator in managing the process of a maternal death.

- The on call Midwifery Manager will ensure the completion of an Electronic Incident Form

- The Co-ordinator will maintain accurate, confidential and contemporaneous records throughout this process of events, ensuring to note the names of all staff involved.

- A maternal death is uncommon and the experience can be traumatic for all concerned. Consideration should be given to releasing staff who are directly involved from the remains of their shift to ensure subsequent patient care is not affected by impaired clinical judgement.

- A midwife/nurse will be allocated to care for the relatives and provide initial support and guidance.

- The Consultant-on-call should be contacted to attend (if not already present). For Deaths in the community inform on call consultant.

- The Consultant should meet with the relatives as soon as possible following the event. The Consultant should not offer any definitive information until the full facts of the case have been investigated and are available, but inform relatives that an investigation will be undertaken.

- The local site on call manager should be informed.

- Inform Lead Obstetrician for Obstetrics, Divisional Head of Midwifery and Executive team as soon as possible following the event.

- Inform the Governance Midwife as soon as events allow. This will be investigated as part of the Health board serious incident policy

- The named Consultant should be informed of events at the earliest opportunity (if not on duty).

- If the cause of death is unknown or within 24 hours of surgery, the Consultant present at the time of the death is responsible for informing the Coroner. In the event of a woman dying at home, if a community midwife is present then she will inform the on call midwifery manager and the senior midwifery manager will inform the coroner.

- If suspicious circumstances are suspected, the police must be informed

- Alert employer wellbeing service so that staff can be prioritised for support.

- Inform the mortuary

- Contact Health Board on call Chaplain via switchboard to pass on appropriate religious support available, or where none to offer support directly

- Inform woman's named Health Visitor, General Practitioner at the earliest opportunity and additionally, the named midwife if death occurs whilst pregnant or within 4 weeks of delivery.

- The designated registered staff will inform MBRRACE as soon as possible (see appendix 4 for process)

- Coordinator to inform staff of the agreed forum for shared learning opportunities in relation to the maternal death

- Establish next of kin contact details and confirm designated contact person as this may not always be the next of kin. Agree that all information will be via that person, and agree telephone contact numbers.

- Offer designated contact person contact number of a designated family contact staff member for any enquiries.

- Contact & refer to social services if support required for relatives within the community.

- In the event of a in utero death in association with maternal death, the following should be considered:

- Over 24 weeks gestation it is a legal requirement to register the death as a stillbirth. If an attempt has been made to resuscitate the baby and then the baby subsequently dies, it must be registered as a neonatal death. If at post-mortem the baby is removed by the

Pathologist, then it is not recognised as a stillbirth and cannot be registered as such as the baby has not issued forth from the mother. There are obvious issues concerning the death of a woman during pregnancy and it is therefore essential to maintain good communication with the family throughout. If the family have difficult questions or queries the discussion with the coroner, registrar for births and deaths or hospital pathologist would be advisable.

- The designated registered staff will include information relating to stillbirth if applicable when notifying MBRRACE.

Appendix 3 Checklist for maternal death

Named Co-ordinator:______________________ Date: ____________

Who to Inform	**Informed**	**Date/ Time**	**Deaths out of area**
1. Contact the obstetric and anaesthetic Consultant-on-call (if not already present)			N/A
2. Arrange for Consultant to meet with relatives as soon as possible			N/A
3. Contact/inform named Consultant Obstetrician and Clinical Director for Obstetrics as soon as possible (if not on duty)			
4. Contact the Divisional Head of Midwifery, and notify the Senior on call manager for the site			
5. Inform the Governance Midwife			
6. Contact Supervisor of Midwives and inform her of the maternal death			
7. Inform clinical Midwifery Manager as soon as possible			
8. Inform the Clinical supervisor for Midwives when next on duty (by email if out of hours)			
9. Identify an individual to care/support relatives present			
10. Consultant to inform the Coroner Note the death certificate is issued by the Coroner			N/A
11. The designated registered staff will inform MBRRACE as soon as possible (see appendix 4 for process)			
12. Suspicious circumstances – inform Police			N/A
13. Notify the hospital chaplain via switchboard			N/A

14.Inform woman's named Midwife, General Practitioner and Health Visitor as soon as possible			
15.Inform Social Services (depending on required support)			
16.If associated death of baby – notify MBRRACE			
17. Alert employer wellbeing service so that staff can be prioritised for support.			

Tasks to be Completed	**Com pleted**	**Date/ Time**	**Out of Area Death**
1.Post mortem discussion regarding the fact that this will be a coroners case			N/A
2.Consent form signed			N/A
3.Case notes and attached documentation photocopied			
4.Stillbirth certificate –if applicable			N/A
5.electronic Adverse incident form completed			
6.Last offices as per Health Board policy Advice from Home Office Pathologist states that all items (MS&E and medication used prior to the death and during resuscitation should remain insitu (e.g. ET tube) or collected and sent with the body for post mortem			N/A
7.Advice to relatives regarding registering of death - **Note the death certificate is issued by the Coroner**			N/A
8.Establish next of kin contact details and confirm that all information will be via that person			
9. Offer next of kin contact number of a designated family contact staff member for any enquiries.			

Provide support group leaflets as appropriate

Provide family with health advice leaflets for baby care if appropriate

Appendix 4 - Notification of maternal death to MBRRACE

MBRRACE UK guidelines for Perinatal and Infant death data entry can be found at:

Useful Contact Numbers:

Local Registrars:

Abergavenny (01873) 735435
Newport (01633) 235510
Caerphilly (01443) 863385
General Enquiries (0151) 4714805
Coroner

Head of Midwifery: (01633) 236043

MBRRACE – 01865 289715
MBRRACE-uk@NPEU.ox.ac.uk