Reference Number: UHBOBS083 **Version Number: 4**	**Date of Next Review: 17/05/2022** **Previous Trust/LHB Reference Number: N/A**

Maternal Death
Standard Operating Procedure

Introduction and Aim

Within Cardiff and Vale UHB, following the death of a loved one, we serve to support relatives and staff involved in any event. Maternal deaths are rare events and the following guidelines serve to support staff in ensuring effective management of such situations.

Objectives

- All mandatory and statutory procedures are completed

Scope

This policy applies to all healthcare professionals in all locations including those with honorary contracts

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	Guidance for Care of the Deceased following an Unexpected Death. Link
Approved by	*Maternity Professional Forum*
Accountable Executive or Clinical Board Director	*Ruth Walker, Executive Nurse Director*
Author(s)	*Senior Midwifery Team c/o Suzanne Hardacre, Head of Midwifery and Lead Directorate Nurse*

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	Jan 2006	Jan 2006	New Document
2	Jan 09	Jan 09	Updated by L Stephenson
3	Dec 11	Feb 12	Updated by S Spencer and L Stephenson
4	17/05/2019	21/05/2019	Reviewed and Updated by Senior Midwifery Team

Access and follow the Health Board Guidance for the Care of the Deceased following an Unexpected Death

1 Table of Contents

2 Definitions

The International Classification of Diseases (ICD 10) (WHO 1992) provides definitions of a maternal death as direct, indirect, coincidental and late as follows:

2.1 Maternal Death

A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Maternal deaths are subdivided into two groups:

• **direct** obstetric deaths: direct obstetric deaths are those resulting from obstetric complications of the pregnancy state (pregnancy, labour and the puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

• **indirect** obstetric deaths: indirect obstetric deaths are those 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 physiologic effects of pregnancy.

2.2 Late Maternal Death

A late maternal death is the death of a woman from direct or indirect causes more than 42 days but less than one year after termination of pregnancy.

3 Managing a Maternal Death

Arrange for the Consultant on duty / on call to meet with the relatives as soon as possible following the event. The Consultant should not offer any information until the full facts of the case have been investigated and are available.

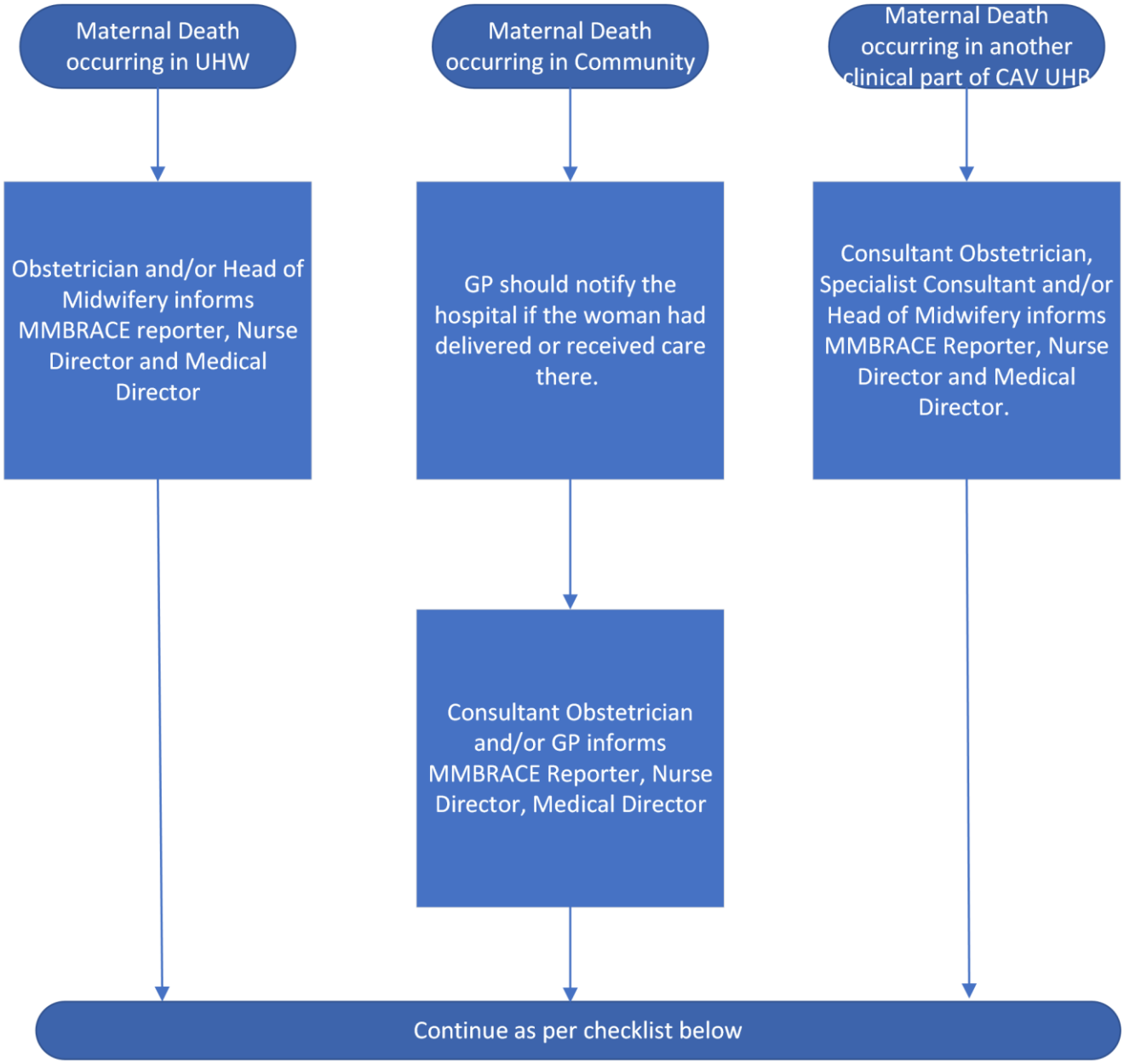
In the event of the baby dying in utero, the following should be taken into consideration:

- Section 41 of the Births and Deaths Registration Act 1953 states that the baby is not defined as a stillbirth / IUD in this instance, even when removed from its dead mother at post mortem. This is because the post mortem is being carried out on the mother rather than the baby. Therefore, registration of a baby, in these circumstances, over 24 weeks gestation as a death is not legally required. However, consideration must be shown to family and explanations given.

MBRRACE-UK (2018) (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) triennial report on maternal deaths is based on the collation of information from maternal deaths, and serves to identify where improvements in the provision of care (clinical and non-clinical) may help to inform practice and prevent future deaths. Professionals from primary and secondary sectors contribute to the MBRRACE due to their recognition of a maternal death and prompt notification to the appropriate personnel.

A maternal death can occur in the community or hospital. Where a maternal death is associated with a pregnancy, it is the responsibility of the lead MBRRACE reporter to MBRRACE. When the death is a *late* death the named lead professional providing care is responsible for informing the Regional Manager, who then initiates an enquiry into the death.

4 Maternal Deaths Flowchart and Checklist



Mother's Addressograph			
Immediate Actions		**Personal Responsible Print and Sign**	**Date / Time**
1.	Contact the Consultant Obstetrician on call (if out of hours). Name of Consultant on call:		
2.	Inform Senior Midwifery Manager on duty or on call as soon as possible. Name of Senior Midwife Manager:		
3.	The maternal records in entirety must be photocopied as soon as possible. All pages must be numbered prior to photocopying		
4.	Allocate a clinician to care / support any relatives who are present. Name of Clinician:		
5.	If the cause of death is unknown or within 24 hours of surgery, the Consultant Obstetrician present at the time of the death is responsible for informing the Coroner's Office immediately. The Coroner must be informed on the next working day. N.B. in an unexpected death cannulas, tubes, drains etc. must be left in position		

Mother's Addressograph

	Immediate Actions (contd)	Personal Responsible Print and Sign	Date / Time
6.	If there are any suspicious circumstances, inform the Police. Please see Section 1, page 6 of the Health Board Guidance for Care of the Deceased following an Unexpected Death (link).		
7.	On the advice of the Consultant Obstetrician on duty / on call, inform the on call Pathologist via Switchboard		
8.	Notify Chaplaincy Department via Switchboard or on call Chaplain should the family require a specific denomination for religious support.		
9.	Senior Midwife Manager on duty or on call to consider notifying safeguarding services if appropriate.		
10.	If out of hours Senior Midwife Manager on call to inform Site Manager on call		
11.	Consultant Obstetrician on duty or on call to inform Clinical Director.		
12.	Senior Midwife Manager on call or on duty to complete DATIX incident report. DATIX Number:		
13.	Care of the Deceased to be as set out in Health Board Policy		

Mother's Addressograph			
Actions to be completed within first 24 hours		**Personal Responsible Print and Sign**	**Date / Time**
14.	Identify named Consultant. Inform on next working day		
15.	Arrange for Obstetric Consultant to meet with relatives as soon as possible following the event.		
16.	Inform Mortuary		
17.	Inform woman's named midwife		
18.	Inform woman's GP		
19.	Inform woman's Health Visitor		
20.	Ensure all records are contemporaneous and all entries signed and dated. All clinicians must identify themselves clearly.		
21.	If a student midwife has been involved in any aspect of care the Senior Midwife Manager must inform the Lead Midwife for Education		
22.	Senior Midwife on next working day to contact Patient Safety Team		
23.	Inform UHB Lead Nurse for Bereavement		
24.	Inform Bereavement Midwife (for information only)		
25.	SI reporting to be initiated		
26.	A Clinical Supervisor for Midwives should be informed at the earliest opportunity in order to provide support for staff.		

	Mother's Addressograph		
	Actions to be completed within first 24 hours (contd)		
27.	Provide advice and information to relatives regarding registering the death. Available in "Bereavement Help and Advice Booklet" link		

	Further Actions to be Completed)		
28.	MBRRACE reporting to be commenced as soon as possible by lead MBRRACE reporter.		
29.	Post mortem discussion by Consultant Obstetrician. Offer written information.		
30.	Post mortem consent form signed. (Not required if Coroner's post mortem necessary. Specific form completed with Coroner's Officer)		
31.	Assistance provided for making an appointment for collecting Death Certificate. The medical certificate for the cause of death should be written at the Bereavement Office. They will inform the family when the certificate is ready for collection.		

5 References

Births and Deaths Registration Act 1953. Accessed online at: http://www.legislation.gov.uk/ukpga/Eliz2/1-2/20

MBRRACE (2018) Saving Lives, Improving Mothers' Care. NPEU, accessed Online at https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202018%20-%20Web%20Version.pdf

World Health Organisation: International Statistical Classification of Diseases and related health problems, 10th revision. Geneva, World Health Organisation, 1992