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Maternal Death

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AUTHORSHIP, RESPONSIBILITY AND REVIEW

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Disclaimer

When using this document please ensure that the version is the most up to date by checking the Obstetrics & Gynaecology Guidelines on WISDOM

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1. Purpose

Professionals who are involved in providing both primary and secondary care play an important role in participating in the Confidential Enquiry into Maternal Deaths by first identifying that a maternal death has occurred, and secondly, by ensuring that the appropriate professionals have been notified.

The aim of the following document is to assist and support all health professionals involved in dealing with a maternal death. MBRRACE require all deaths of pregnant women and women up to one year following the end of pregnancy (regardless of the place and circumstances of the death) to be reported to them. The document outlines the procedure to be followed by health professionals in the event of a maternal death

2. Scope

This document applies to all midwifery and medical staff employed by Cwm Taf Morgannwg University Health Board working in any capacity in the Health Board.

3. Introduction

In 2012 a new organisation was set up to look into continuing the work previously undertaken by the confidential enquiry into Maternal and Child Health (CEMACH). The new organisation looks at reducing risk through audits and confidential enquiries across the UK (MBRRACE). It is anticipated that MBRRACE will produce an annual report with triennial data detailing all reported cases of maternal deaths including those late deaths (from 42 days – 1 year). MBRRACE annual report also includes surveillance data on women who died during or up to a year after pregnancy and also includes confidential enquiries into key conditions or complications which may lead to maternal morbidity.

The aim is to provide a report to ensure we continue to learn lessons from the deaths of women during and after pregnancy.

The definition of a maternal death is included in Appendix 1.

4. Notifying MBRRACE and Completing the Enquiry Form

Following the reporting of a maternal death to MBRRACE a notification pack is sent out to the unit in which the death has occurred. This includes a surveillance form to collect basic demographic and clinical details about the death, together with a form requesting the details of the clinicians involved in managing the woman's care. The hospital MBRRACE-UK contact (Governance Lead Midwife) is asked to return the completed surveillance form together with the details of the local clinicians within one month of the death occurring. The hospital MBRRACE –UK contact is also asked to return a full photocopy of the woman's medical records.

After these documents have been returned, the MBRRACE-UK team send out local clinicians report forms to the clinical staff involved in the woman's care. These ask for the staff perspectives on the care of the woman, and ask them to identify any lessons learned for future care. These documents together with the woman's medical records are fully anonymized, scanned and uploaded onto the MBRRACE-UK secure viewing system for independent assessment by MBRRACE-UK trained assessors. The aim is to have all data complete and ready for assessment by three months from the date of the woman's death.

5. If the death of the baby has also occurred?

In the event of a baby dying in utero, the following should be considered:-

- Over 24 week's gestation – it is not a legal requirement to register the death of a stillbirth. However, if the baby is removed and an attempt has been made to save the baby and the baby then dies, it is to be registered as a neonatal death.
- If at post-mortem the baby is removed by the Pathologist then it is not considered to be a stillbirth. This is because the post mortem is being carried out on the mother rather than the baby.
- A medical practitioner may issue a death certificate for the dead baby as stillborn and some Registrars of Births, Deaths and Marriages will comply but, to avoid confusion and further distress to the family the above advice should be followed.
- It is considered good practice to follow the procedure for managing a stillbirth/neonatal death as this will detail whether or not the baby is to be registered or not.

Support for staff

The staff involved in the case will require both professional and personal support. The Midwifery Matron/Senior Midwife, line manager or Clinical Supervisor for Midwives will provide support for midwives; the Labour ward lead will support medical staff. It may be necessary to provide an experienced counsellor for staff and referral to Occupational health for Wellbeing at work support. The Obstetric and and Midwifery Governance leads will have responsibility to provide a timely debriefing session with staff involved on a group of individual basis.

Checklist following Maternal Death

The procedure for dealing with a maternal death in the acute/hospital setting.

A maternal death may occur in a variety of settings, for example the Intensive Care Unit or Accident & Emergency department. It is important in the absence of the Midwifery Matron/Senior Midwife that the Labour Ward Co-ordinator supports appropriate departments within the hospital to give appropriate advice in relation to the management of maternal death.

Tasks to be completed & personnel to be notified	**Completed by Date and initials**	**Comments**
Ensure on call Consultant Obstetrician is informed.		
Inform Head of Midwifery/Midwifery Matron/Senior Midwife.		
On call Consultant Obstetrician:- • To meet/speak to relatives as soon as possible • To discuss Post Mortem and request consent • To Inform the Pathologist on call • Advise that Coroner's Office will be informed if cause of death is unknown or within 24 hours of surgery.		
If suspicious circumstances are suspected the police should be informed immediately and access to the deceased should be restricted.		
Advice from Home Office Pathologist states that in the event of an unexpected death, any items or medication used prior to the death and during resuscitation (eg tubes, IV Infusions and/or drains) must be left in-situ.		
If recently delivered the placenta should be labelled and accompany the body to the mortuary.		
In the event of the birth of a live baby, it is important that parental responsibility be established at the earliest opportunity.		
Inform Social Services if required for baby.		
Ensure the procedure for performing Last Offices is adhered to (as per CTMUHB Policy), respecting any religious beliefs.		
Contact religious denomination (if requested)		
Inform/Contact Bereavement midwife for advice and support for family.		
Ensure whenever possible that the death certificate (and certificate of stillbirth if applicable) is issued to the next of kin. This should be completed accurately and promptly and a follow up meeting arranged to discuss the investigation and findings of the review.		

Tasks to be completed & personnel to be notified (Contin…)	**Completed by Date and initials**	**Comments**
Advise the relatives on when the body can be viewed in the Chapel of Rest.		
Ensure Lead Obstetrician is informed.		
Appoint a Midwifery Matron/Senior Midwife as point of contact for the family.		
Local MBRRACE Co-ordinator (Governance Lead Midwife) to be informed next working day to report case.		
Inform: • Coroner's office • General Practitioner • Community Midwife if death occurs while pregnant or within 4 weeks of birth • Health Visitor.		
Clinical Supervisor for Midwives to be informed to provide support to the midwives. Labour ward lead to provide support to medical staff.		
Advise staff involved that witness statements will be required.		
If a student midwife or medical student has been involved in any aspect of care, relevant University to be informed.		
Photocopy complete set of medical records including all antenatal records and pathology reports.		
Report incident on Risk Management System (DATIX).		
Notification to Welsh Government must be completed (Serious Incident Reporting form SI on the next working day).		
If the deceased woman has been admitted having been treated or booked in another Health Board then the senior midwife and consultant in that area should be informed.		
Ensure the deceased is marked as so on the Hospital Administration system and Welsh PAS system and all future appointments cancelled. Bounty and associated pregnancy teams will need to be informed that the mother will need to be removed from their mailing lists.		

The procedure to follow when dealing with a maternal death that occurs suddenly and unexpectedly within the community setting including a death that occurs within a Midwifery Led Unit (MLU).

Note: In those instances where a death has been expected / reported incidentally to the community midwife then the following guidance need not be followed but the Head of Midwifery should still be informed.

1. The maternity unit matron will provide initial advice and guidance for managing
   the death and will support completion of the above checklist where relevant.

2. In the event that paramedics have been called and are unsuccessful in their attempts at resuscitation, the deceased should not be moved unless transfer to hospital of the woman is recommended by the paramedics. The police should be notified of the death and the area secured until they arrive. The woman's maternity records and any records completed by the midwife during the resuscitation should be secured.

3. Dependant on the situation an additional on-call midwife should be called to the incident and be allocated to care for the relatives and provide initial support and guidance.

4. If the cause of death is unknown, the GP on call at the time of death is responsible for reporting the death to the coroner. This contact number is available through the main hospital switchboard.

7. Where to go and whom to contact for further advice

1. The designated MBRRACE-UK contact will advise on any information that is required if the baby has also died.
2. The coroner is also able to advise on individual situations/circumstances and is contacted via the police station in the relevant area of South East Wales.
3. Further advice in the reporting of a maternal death may be sought from the regional manager for MBRRACE.
4. MBRRACE web site: this site will provide further information on the function of MBRRACE**:** **www.npeu.ox.ac.uk/mbrrace.uk Tel:+44-1865-289715**
   Email: mbrrace-uk@npeu.ox.ac.uk/mbrrace-uk

References

MBRRACE-UK Saving Lives, Improving Mothers Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-2016. Nov 2018. NPEU:Oxford

APPENDIX 1 (MBRRACE –UK)

The Definition of Maternal Death (World Health Organisation 2010)

Maternal Death – Death of a woman while pregnant or within 42 days of the end of pregnancy* from any cause related to or aggrevated 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 the result of direct obstetric causes, but which was aggravated by the physiological effects of pregnancy.

Late - Deaths occurring between 42 days and 1 year after the end of pregnancy* that are the result of Direct or Indirect maternal causes.

Coincidental – Deaths from unrelated causes which happen to occur in pregnancy or the puerperium.

*Includes giving birth, ectopic pregnancy, miscarriage and termination of pregnancy.