In the Event of a Maternal Death Policy

Policy information

Policy number: 1090
Classification: Clinical
Supersedes: Version 1
Local Safety Standard for Invasive Procedures (LOCSSIP) reference: *N/A*
National Safety Standards for Invasive Procedures (NatSSIPs) standards: *N/A*
Version number: 2.0
Date of Equality Impact Assessment: 14.01.2026

Approval information

Approved by: Clinical Written Control Documentation Group
Date of approval: 20.02.2026
Date made active: 26.02.2026
Review date: 20.02.2029

Summary of document:
The aim of the following document is to assist and support all health care 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 care professionals in the event of a maternal death.

Scope:
This document applies to all health care professionals employed by Hywel Dda University Health Board working in any capacity in the Health Board. The guidance below uses the term 'woman' (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male, or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women's health and reproductive services. Therefore, this should include people who do not identify themselves as women, but who are pregnant or have recently given birth. Obstetric and Midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex that they were assigned at birth

To be read in conjunction with:
947 Care of a neonate and family after a neonatal death -opens in new tab
269 - Verification of Death Policy -opens in new tab

Patient information:
N/A
Owning group:
Maternity Working Control Document Working Group

Executive Director job title:
Andrew Carruthers, Chief Operating Officer

Reviews and updates:
1.0 – New Policy – 17.06.2022
2.0 Reviewed

Keywords
Maternal Death

Glossary of terms
Direct Maternal Death - 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
MBRRACE - Mothers and Babies Reducing the Risk through Audit and Confidential Enquiries
MCCD - Medical Certificate of the Cause of Death

Contents

Introduction

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 pregnant people and women and people up to one year following the end of pregnancy (regardless of the place and circumstances of the death) to be reported to them. This policy sets the procedure to be followed by health professionals in the event of a maternal death.

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). 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 of the MBRRACE report is to provide a report to ensure we continue to learn lessons from the deaths of women and birthing people during and after pregnancy.

Policy statement

A maternal death is likely to have a significant impact on all members of staff involved. Sensitive, nonjudgmental support should be available for all staff. Possible resources include colleagues, managers, and occupational health staff. Staff psychological wellbeing and staff counselling and support services are also available for all staff members.

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.

Scope

This Policy applies to all working within the Children, Women and Family Health Clinical Care Group, who may be involved in a woman's death during or within one year of pregnancy, childbirth, or abortion which is directly or indirectly related to these conditions.

This policy covers maternal death that occurs within 42 days of pregnancy within maternity services. It may also apply to deaths from pregnancy related causes within other areas of Hywel Dda University Health Board.

In practice this will include Obstetricians, Gynaecologists, all Midwives (based in hospital or community), Nurses, and Managers within the Maternity Service.

Other health care professionals who may find the guideline of use include Medical Examiners, General Practitioners, Health Visitors, Community Nurses, Practice Nurses, Psychiatric and Community Psychiatric Nurses, Surgeons, Mortuary Staff, Hospital Nurses, those working within the Accident and Emergency department and those working within the Intensive Care Unit and Pathology Consultants.

Aim

The aim of this document is to:

- Not aim to replicate standard procedures to be followed following the death of an inpatient but seeks to supplement them in relation to maternal death. This Policy does not address clinical issues that may exist prior to and after maternal death occurs.
- To meet the statutory responsibility of the Health Board to notify the Confidential Enquiry that a maternal death has occurred

Objectives

The aim of this document will be achieved by the following objectives:

- To provide the knowledge and guidance to healthcare professionals with information about the statutory responsibilities to notify the Confidential Enquiry that a maternal death has occurred.
- To ensure that professionals involved are able to follow the expected procedures in order to inform all relevant personnel, provide clear and accurate information for the next of kin, and minimise any potential delays.
- To clearly detail avenues of support and further advice for healthcare professionals.
- To provide clear roles and responsibilities of healthcare professionals within the organisation.

Support for Staff

A maternal death is a traumatic and harrowing experience for those involved and is likely to have a significant impact on staff. Therefore, staff involved in the case will require both professional and personal support.

In maternity the Senior Midwifery Manager, line manager or Clinical Supervisor for Midwives will provide support for midwives; the Labour ward lead / obstetric clinical lead will support medical staff. It may be necessary to provide an experienced counsellor for staff and referral to Occupational health / Staff Psychological Wellbeing Service for wellbeing at work support. The Obstetric and Midwifery Governance leads will have responsibility to provide a timely debriefing session with those involved in a group or individual basis depending on the wishes of staff.

Definition of a Maternal Death

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 physiological effects of pregnancy .

Late: Deaths occurring between 42 days and one year after termination of pregnancy, miscarriage or delivery that are due to Direct or Indirect maternal causes

Coincidental: Deaths from unrelated causes which happen to occur in pregnancy or the puerperium (such as road traffic accidents)

Note that both deaths during pregnancy and within 42 days of pregnancy, and late deaths up to 1 year after pregnancy, have a statutory reporting requirement to the Confidential Enquiry run by MBRRACEUK. These deaths may occur within the maternity service, in other hospital departments, or in the community. If there is any doubt about whether a death needs reporting, the Clinical Risk and Governance Team should be contacted on 01267 283 270.

Location of a Maternal Death.

When a woman dies unexpectedly in another part of hospital or in the community (not in maternity)in immediate postpartum period.

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 Senior Midwifery Manager that the Labour Ward Co-ordinator is available to support appropriate departments within the hospital and refer to this guideline to give appropriate advice in relation to the management of maternal death.

When the woman dies outside the maternity service the on-call consultant and the senior midwifery manager for that site should be informed as soon as possible.

If the death occurs shortly after admission without the maternity staff, then the maternity team needs to be involved at the earliest opportunity and the on-call consultant and the senior on call midwifery manager should be informed.

Women who have been on the intensive care unit for a period of time, the maternity and/or gynaecology should already be involved in the woman's continuing care and should be informed of the woman's death as a matter of routine.

When a maternal death occurs in early pregnancy , or a pregnant woman collapses in the community and is bought into Accident and Emergency department ,maternity and gynaecology personnel may not be involved in the immediate care, Never the less all staff should be encouraged to see advice from the maternity unit, the on-call consultant , the head of midwifery or the out of hours senior on call maternity manager via switchboard to ensure that the correct processes in relation to a maternal death are followed.

When a maternal death occurs after being discharged postnatally from midwifery care.

- After a maternal death when the woman has been discharged from maternity care (approximately 4-6 weeks postpartum) but less than one year post-partum the maternity services are not automatically informed .
- In these cases, clinicians should refer to the health board's Care after Death policy –opens in a new tab .
- The certifying medical practitioner is required to complete the Medical certificate of Cause of death (MCCD) and answer if there is any information to suggest that the deceased woman has been pregnant within the year before she died, regardless of the cause of death. This is to ensure that there is complete recording of maternal deaths nationally (MBRRACE) , and that pregnancy is always considered as a possible cause of death
- In order to inform maternity services a DATIX should be completed so that the Governance Midwife can commence an investigation as part of the health board serious incident policy.

Procedure should Maternal Death occur within Maternity Services

Refer to Appendix 1 for the procedure should maternal death occur within maternity services and Appendix 2 for the flowchart/checklist.

Dealing with a Maternal Death that occurs suddenly and unexpectedly in the maternity community setting.

(see Appendix 3)

Designated Person

One person should be nominated to ensure that all appropriate policies are followed. For the maternity service this will usually be the Clinical Risk and Governance Team and in their absence the Quality Assurance and Safety Team.

The co-ordinator needs to make sure that all aspects of the maternal death checklist are considered, and completed where necessary, if they are unable to achieve this then it should be escalated to the Midwifery Manager on call.

Staff involved in the death should ensure they write up their notes before going off duty with clear, legible, factual details of their actions and events. The notes should also include what the partner/family members have been told, and what they understand of the events surrounding the death.

Death Certification and Coroners Referral/ Medical Examiner Service pathway

A medical practitioner who has attended the woman in her last illness should attend Bereavement Services with the medical notes on the first available working day after the death. It is preferable that this doctor is the most senior doctor to attend in the last illness (i.e. the consultant) or should have discussed the case with the consultant. The circumstances of the death should be discussed with the duty Medical Examiner for the Health Board, who will decide whether coroner's referral is required (2). If referral to the coroner is needed, this should be completed by the doctor using the online referral form. If a coroner's referral is not required, then the cause of death should be agreed with the Medical Examiner, and the Medical Certificate of the Cause of Death (MCCD) should be issued.

Maternal death is not an indication for automatic referral of a death to the coroner. The coroner will want to investigate deaths that are suspected to be in any way 'unnatural,' and the Medical Examiner will wish to establish whether that is the case. If referral to the coroner is not indicated follow the Medical Examiner Service pathway (see appendix 4).

If the family require early release of the body for religious purposes, then Refer to the Health Board guideline (3). The on call Medical Examiner can be contacted via the Duty manager of the Health Board to authorize early release. Early release is not possible if coroner's referral is required.

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 Southwest Wales (Dyfed Powys Police).

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** (opens in new tab)

5. Email: mbrrace-uk@npeu.ox.ac.uk/mbrrace-uk

Responsibilities

Chief Executive

As Accountable Officer, the Chief Executive has overall responsibility for ensuring the health board has appropriate WCDs in place. These WCDs must comply with legislation, meet mandatory requirements, and provide services that are safe, evidenced-based, and sustainable.

Head of Midwifery

The Head of Midwifery is responsible for ensuring there is a guideline in place for the management of maternal deaths which is line with national guidance and legislation, irrespective of the location of the maternal death. The Head of Midwifery is responsible for ensuring there is a designated local MBRRACE co-ordinator within maternity services and that that all maternal deaths are notified to MBRRACE. It is the responsibility of the hospital or Health Board where the mother and / or baby died to notify the case to MBRRACE. If the death occurred in a community setting it would be the responsibility of the hospital where the mother's body was taken to after they had died to notify the case to MBRRACE.

Clinical Lead Obstetrician and Clinical Director for Children, Women and Family Health Clinical Care

The Clinical Lead Obstetrician and Clinical Director for Children, Women and Family Health are responsible for ensuring that the WCD is implemented following a maternal death and will liaise closely with the Head of Midwifery and Consultant Obstetrician to ensure that this WCD is implemented. The Clinical Lead Obstetrician and Clinical Director will collaborate with the Head of Midwifery to ensure that the case has been notified to MBRRACE.

Head of Quality and Governance

The Head of Quality and Governance is responsible for ensuring that this WCD has been implemented and that a proportionate investigation is undertaken in a timely manner and that initial findings are shared at the earliest opportunity with the Quality and Governance Team in line with the Health Board's internal and external review process.

Consultant Obstetricians

The consultant obstetricians will ensure that all medical staff are aware of their responsibilities within the guideline and ensure all medical staff involved in a maternal death are supported. Ensure that the guideline is followed Ensure that all maternal deaths are notified to MBRRACE and meet with the next of kin at the earliest opportunity.

Risk and Governance Lead Midwife and Obstetrician

The Risk and Governance Lead Midwife & Obstetrician will be responsible for leading the investigation and will act as a single point of contact to avoid conflicting information with the family. The Risk and Governance Lead Midwife & Obstetrician will collaborate with the Head of Midwifery and Consultant Obstetrician to ensure that all staff involved are adequately supported following a maternal death. The Risk and Governance Lead Midwife is responsible for ensuring that the Head of Quality and Governance is informed in the event of a maternal death.

Midwifery Manager on Call
The Midwifery Manager on Call is responsible for ensuring that the WCD has been implemented in the event of a maternal death. The midwifery manager on call is responsible for informing the Head of Midwifery, if not already informed, and will attend to support staff in the event of a maternal death and act as point of contact for the family

The Midwife in Charge of the Shift
The Midwife in charge will ensure the appropriate people are informed (See Appendix 1). Determine if the next of kin wish any religious or spiritual support to be offered by the hospital chaplain. If the mother dies in the Emergency Department or another location in the hospital, then midwife in charge should either be present or allocate a member of the midwifery team to provide pastoral care to the family. The Midwife in Charge is responsible for informing the midwifery manager on call. The midwife in charge will act as a single point of contact until the midwifery manager on call / Head of Midwifery arrives. If the baby is a live birth: consider who has parental responsibility (gain advice from on-duty social worker and who will provide the immediate care for the infant, refer to local safeguarding midwife as required.

Consultants in other Care Groups
Consultants in other care groups are responsible to inform the duty consultant obstetrician and Head of Midwifery of any maternal death which occurs in a department in the Health Board than maternity.

Nurses in other Care Groups
Nurses in other care groups are responsible for informing the Midwife in Charge of the shift of any maternal death which occurs in a department in the Health Board than maternity.

References

1. Knight M, Bunch K, Tufnell D, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland
2. Confidential Enquiries into Maternal Deaths and Morbidity 2017-19. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2021.
3. RCOG . Good Practice paper No.18, Feb 2024 .Managing Events Surrounding a Maternal Death and Supporting the Family and Staff

Appendix 1 – Procedure should Maternal Death Occur

1. If not already present, medical and senior nursing / midwives should be called.

2. The death should be verified (Refer to 269 - Verification of Death Policy (opens in new tab)) and documented in the case notes by a qualified medical practitioner.

3. Patient's next of kin and relatives must be informed of the death, and appropriate and sensitive care should be offered:
   - The next of kin.
   - However, it is acceptable to inform whomever the deceased woman has documented as her next of kin in her Antenatal notes.

4. If relatives or next of kin are not present at the time of the woman's death they should be informed as soon as possible. They may wish to view the body before last offices are completed.

5. The Consultant on Call must be informed, if not already present, and should meet with the next of kin as soon as possible. The named consultant (if different) must also be informed when next on duty.

6. At an appropriate time in relation to next of kin last offices should be performed, and the body transferred to the mortuary.

7. It may be appropriate to inform other patients of the death, as they may be aware that a death has occurred. Support and reassurance can be offered and questions answered sensitively. This decision, however, must be taken in relation to individual circumstances at the time to the death and must not breach patient confidentiality.

8. Next of kin may wish their religious advisor to be notified. The hospital chaplain is also available for support if requested.

9. An experienced nurse or midwife should be nominated to act as supporter to the woman's family until the midwifery manager takes over the role. This person will also act as their main point of contact to prevent conflicting information being given. This must be documented in the case notes.

10. The on-call Midwifery Manager should be informed in all cases where a maternal death occurs. Contact numbers are kept on labour ward in GGH / Gwenllian ward BGH

11. The Head of Midwifery should be informed when a maternal death occurs on the Maternity Unit even if it is out of hours

12. Maternal Death checklist must be completed in all cases (See Appendix 2).

13. Infant bereavement notification / MBRRACE forms should be completed where necessary.

14. The Clinical Risk and Governance Lead Midwife should be informed as soon as possible.

15. The Community Midwife and General Practitioner should be informed as soon as possible.

16. Relevant professionals must be informed as soon as possible: Clinical Risk & Governance Lead Midwife, CMG Medical Lead, Head of Service and Head of Midwifery and Nursing. The Clinical Risk and Quality Team will inform the Management team, who escalate it to Board level where necessary via the Corporate Patient Safety Team.

Appendix 2 – Flowchart to be Completed in the Event of a Maternal Death

Patient name:
DOB:
Address.

Date

GGH/ BGH/ Other ……
Ward……

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 Manager on call.		
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 (e.g 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 HDUHB Policy), respecting any religious beliefs.		

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.		
Advise the relatives on when the body can be viewed in the Chapel of Rest.		
Ensure Clinical Lead Obstetrician / Labour ward lead is informed.		
Appoint a Midwifery Matron/Manager as point of contact for the family.		
Local MBRRACE Co-ordinator (bereavement midwives) to be informed next working day to report case.		
Inform: • Coroner's office **or** • Complete Medical Examiners pathway • 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.		
Advise individuals involved that witness statements will be required.		
If a health care student (student midwife, medical student, student paramedic) 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 the Delivery Unit must be completed (Nationally Reportable Incident notification form)		
If the deceased woman has been admitted having been treated or booked in another Health Board		

then the manager on call and consultant on call 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.		

Appendix 3 - Dealing with a Maternal Death that Occurs Suddenly and Unexpectedly within the Community Setting

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 operational lead midwife for community / midwifery manager on call will provide initial advice and guidance for managing the death and will support completion of the above checklist (appendix 2) 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.

Appendix 4. Medical Examiner Service

Medical Examiner Service and Death Certification Reforms

Dear colleagues, you should be by now aware that referral to the Medical Examiner (ME) for all deaths has become a statutory requirement from the 9th September 2024. Death certification reform and the introduction of medical examiners - GOV.UK

A ME scrutinises and agrees the terms of the (Medical certificate of cause of death) MCCD. Additionally, the Medical Examiner may wish to discuss this with a qualified attending practitioner (QAP) before the QAP completes the MCCD.

Delays in the completion of the MCCD impacts on limited Mortuary and funeral director capacity, particularly during seasonal peaks in death rates. More importantly, delays in MCCD completion and release of the deceased cause significant distress to next of kin and are increasingly a source of complaints.

The completion of a proposed MCCD cause of death proforma can significantly reduce delays in the Mortality process: https://forms.office.com/e/7FMQBW34y8.

This is a short MS forms document accessible via the link or QR code below to complete a proposed MCCD, contact details for the doctor, colleague and responsible consultant/ General Practitioner, copies of which are transmitted to the MEO. If the ME is happy with the proposed causes of death, then they give the go ahead for completion and if discussion is required, they have contact details at hand.

These issues have been highlighted at a national level through the Medical Examiner Service and the Deputy Chief Medical Officer (DCMO). The adoption of a MCCD proforma has been encouraged at a national level.

We seek this opportunity to make you aware of the above and to thank you for your contribution in addressing the issues identified and subsequently improving the experiences of the bereaved and the timely release of those deceased.

Please do refer to the below FAQs:

FAQS

1. **Where can I get a copy of the form?**

The form is available via:

· MWW Mid & West Wales Team (Hywel Dda and Swansea) – https://forms.office.com/e/7FMQBW34y8

· QR code:

2. When should the form be completed?

As soon as possible after death of the patient, certainly within one working day. It is imperative that the completion of the form does not delay the transfer of notes to the ME service

4. **Where can I get further information on the MCCD process Nationally**: via NWSPP Medical Examiner Service - NHS Wales Shared Services Partnership Nationally via gov.uk Death certification reform and the introduction of medical examiners - GOV.UK This following link may also be of use to you which has specific pages for GP practices: Medical Examiner Service (sharepoint.com).

Link to above Medical Examiner Service information via intranet:
Medical Examiner Service.docx- opens in a new tab.