

In the Event of a Maternal Death Policy

Policy information

Policy number: 1090

Classification:

Clinical

Supersedes:

N/A

Local Safety Standard for Invasive Procedures (LOCSSIP) reference:

N/A

National Safety Standards for Invasive Procedures (NatSSIPs) standards:

N/A

Version number:

1.0

Date of Equality Impact Assessment:

12/09/2022

Approval information

Approved by: Clinical Written Control Documentation Group

Date of approval:

28/10/2022

Date made active:

31/10/2022

Review date:

28/10/2025

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.

To be read in conjunction with:

[947 - Care of a Neonate and Family after a Neonatal Death Guideline](#)

[269 - Verification of Death Policy](#)

Patient information:

N/A

Owning group:

Maternity Working Control Document Working Group

17/06/2022

Executive Director job title:

Mandy Rayani – Director of Nursing, Quality and Patient Experience

Reviews and updates:

1.0 – New Policy – 17.06.2022

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

Policy information.....	1
Approval information	1
Introduction	4
Policy statement.....	4
Scope.....	4
Aim.....	5
Objectives	5
Support for Staff.....	5
Definition of a Maternal Death.....	5
Location of a Maternal Death	6
Procedure should Maternal Death occur within Maternity Services	6
Nominated Person	6
Death Certification and Coroners Referral	6
Where to go and whom to Contact for Further Advice	6
Responsibilities	7
References.....	8
Appendix 1 – Procedure should Maternal Death Occur	9
Appendix 2 – Flowchart to be Completed in the Event of a Maternal Death	11
Appendix 3 - Dealing with a Maternal Death that Occurs Suddenly and Unexpectedly within the Community Setting.....	13

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, non-judgmental 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 Women and Children's Health directorate, 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. 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 physiologic 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 MBRRACE-UK. 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

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 to give appropriate advice in relation to the management of maternal death.

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.

Nominated 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.

Death Certification and Coroners Referral

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 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 coroners 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 South West 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/mbrance.uk Tel:+44-1865-289715 (opens in new tab)
5. Email: mbrance-uk@npeu.ox.ac.uk/mbrance-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 in 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 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 Women and Children's Health

The Clinical Lead Obstetrician and Clinical Director for Women and Children's 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, Tuffnell D, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of
2. MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland
3. Confidential Enquiries into Maternal Deaths and Morbidity 2017-19. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2021

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 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

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:- <ul style="list-style-type: none"> • 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 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: <ul style="list-style-type: none"> • 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.		
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 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.