Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

GUIDELINES FOR REPORTING A MATERNAL DEATH

Document Reference No:	PTHB / MAT 006	
Version No:	4	
Issue Date:	July 2023	
Review Date:	June 2026	
Authors:	Governance and Risk Lead	
Document Owner:	Head of Midwifery & Sexual Health	
Accountable Executive:	Executive Director of Nursing and Midwifery	
Approved By:	Women and Childrens Policies and Procedures Governance Group	
Approval Date:	19 June 2023	
Document Type:	Guidelines	Non-clinical
Scope:	Local guideline for all midwives working in Powys.	

The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

Version Control:

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	June 2012
2	Reviewed and minor changes from CMACE 2011	Feb 2015
3	Reviewed and major changes from MBRACCE updated by Women and Children's Risk and Governance Lead	July 2021
4	Reviewed and major changes from MBRACCE updated by Women and Children's Risk and Governance Lead	July 2023

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Governance and Risk Lead
Safeguarding

Circulated to the following for Consultation

Date	Role / Designation
06/2012	Health Visitors and School Nursing team
06/2012	Women's and Children's Directorate
06/2012	Safeguarding Team
04/10/19	Midwives
04/10/19	Health visitors
04/10/19	Women's and Children's Directorate
04/10/19	Safeguarding Team
11/04/2023	Midwives
09/05/2023	Women and Childrens Policy and Procedures Oversight Group
09/05/2023	Safeguarding
09/05/2023	Director of Nursing & Midwifery

Groups Approved at

Date	Group
05/06/2023	Maternity Guidelines Group
19/06/2023	Women and Children's Policies and Procedures Group

Item No.	Contents	Page
1.	Introduction	4
2.	Causes and Trends	4
3.	Objectives	5
4.	Starting an Enquiry	6
5.	Health Professionals that should be informed in the Event of a Maternal Death	7
6.	Informing the Coroner	8
7.	Managing a Maternal Death in Primary Care	8
8.	Completing the MBBRACE Notification	8
9.	Investigation Process	9
10.	Monitoring Compliance / Audit	9
11.	Review and Change Control	9
12.	References / Bibliography	9
	Appendices	
1.	Actions to be completed in the event of a Maternal Death	10
2.	Information Relating to a Baby who Dies with the Mother	11
3.	Reportable Deaths: A Brief Guide	12

1. 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.

MBRRACE-UK release: Saving Lives, Improving Mothers' Care 2020

The latest report by MBRRACE-UK provides data on surveillance of maternal deaths between 2016 and 2018 which also includes reports for women who died between 2016 and 2018 from mental health conditions, thrombosis and thromboembolism, malignancy and homicide, as well as morbidity related issues.

The aim of MBRRACE-UK is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services. It is therefore important that all cases of maternal death are notified promptly so that full information on each case is readily available. Reporting is accessible via a secure portal on the MBRRACE –UK website.

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

2. Causes and Trends

Overall there has been no change in the maternal death rate between 2011-13 and 2014-16 in the UK in the 2020 MBRRACE report. Maternal death rates from direct causes are unchanged and indirect maternal death rates have significantly decreased.

Assessors judged that 29% of women who died had good care. However, improvements in care which may have made a difference to the outcome were identified for 51% of women who died.

Thrombosis and thromboembolism remain the leading cause of direct maternal death and cardiac disease the leading cause of indirect maternal deaths. There

has been a statistically significant increase in maternal mortality due to Sudden Unexpected Death in Epilepsy (SUDEP). Almost a third of maternal deaths occurring between six weeks and one year after the end of pregnancy were due to psychiatric causes.

Access to and uptake of antenatal care remains an issue amongst women who died. Only a third of women who died received the nationally recommended level of antenatal care.

Notifications of all maternal deaths should be made by ringing the Oxford MBRRACE-UK office on **01865 289715**.
Email: mbrrace-uk@npeu.ox.ac.uk/mbrrace-uk

3. Objectives

The purpose of these guidelines is to assist professionals working in both hospital and community settings, to ensure effective management in the rare event of a maternal death.

The aim of the following guideline is to outline the procedure to be followed by health professionals in the event of a maternal death.

4. Starting an Enquiry

Once the coordinator for the incident has been identified, they must ensure all the personnel listed are informed. The Co-ordinator must ensure that a record of each part of the procedure that has been followed is maintained and saved to SharePoint in the appropriate folder.

The staff involved in the case will require both professional and personal support. Support may be provided by Clinical Supervisor for midwives' sessions or Occupational Health. It may be necessary to provide an experienced counsellor for staff. There will be a debrief session arranged with all staff involved in the care of the woman and the Head of Midwifery, and coordinator of the incident, within one week of the death.

The maternal case notes and all documentation should be completed, photocopied and secured at the first opportunity. The Case notes and associated documentation will be sent to the coroner's office in the event of post-mortem or a case hearing.

The death will be reported via the Incident Reporting system "Once for Wales" and the risk management process for a Nationally Reportable Incident (NRI) will be triggered. A maternal death on site will initiate an internal Route Cause Analysis (RCA) investigation with external independent expert opinion.

An RCA investigation will be initiated in the event of a direct maternal death. This will follow the Incident Safety Framework guidelines and include an immediate safety huddle with HoS, Director of Nursing and Midwifery, Quality & Safety members to discuss the high level timeline within 72hours of the notification.

In the event of the baby also dying, then the local stillbirth/neonatal death procedure should be followed. Specific religious beliefs and practices should be respected. The relatives may wish for their religious leader from their faith to be notified. They may also wish for this person to be with them at the hospital, community setting. If the baby is born alive, consideration must be given to PRUDIC procedures. The DGH will be liaised with to complete the PMRT in partnership where necessary.

The community midwife (midwives) and Health visitors involved in the woman's care must be notified, this includes women booked that live out of area and have received antenatal/postnatal care by midwives from another Health Board.

Arrangements should be made for the woman's family to meet as soon as possible with the Head of Midwifery or appointed contact. Contact numbers and further meetings should be arranged for the family to discuss ongoing concerns and receive updates in regard to the NRI and the initial finding. Subsequent

meetings should be arranged when the results of investigations are available in order for the findings to be comprehensively discussed with the patient's close relatives.

If a woman dies from a genetic or inheritable condition (such as Marfan's syndrome) or potentially inheritable disease such as sudden adult death syndrome (SADS), a follow up appointment should be made for an appropriate time for the family to be offered counselling and screening, if they so wish.

5. Health Professionals that should be informed in the Event of a Maternal Death

A death certificate should be completed by the relevant personnel i.e. woman's consultant, general practitioner or Coroner depending on the circumstances of the death. The death certificate will be issued subject to the Coroners instructions and communication. The relatives will be requested to deliver the certificate to the Registrar of Births and Deaths.

The Head of Midwifery (or nominated deputy) must notify the death to MBRRACE -UK.

If the death of the baby has also occurred, the relevant MBRRACE-UK reporting procedure must be followed, this is the responsibility of the Risk and Governance Lead and Head of Midwifery. Consideration must also be given to PRUDIC procedures in relation to a baby death.

The woman's General Practitioner and Health Visitor must be informed as soon as possible, the next working day.

If the woman has been admitted, having been treated or booked out of area, then the Head of Midwifery and lead consultant at the provider hospital must be informed.

If the death has occurred outside the provider Health Board or within another department, the consultant obstetrician, general practitioner, midwife involved in the care of the pregnancy should also be informed.

Social Services should also be notified depending on the family's social circumstances, or if a live baby requires care, and/or the family require support. Advice should be available for any financial support they may need. If there are school age children in the home, ideally the school should be involved to provide support to the children.

6. Informing the Coroner

The Coroner should be notified if the cause of death is unknown, suspicious or occurs within 24 hours of admission to hospital and he/she will be responsible for ordering a post-mortem. In some areas, the Coroner's Officer may insist on being present when the relatives visit the mortuary.

A police officer known as the Coroner's Officer usually works with the coroner but may not necessarily be based in the same area but may be involved in cases where cause of death is unknown.

7. Managing a Maternal Death in Primary Care

The General Practitioner should contact the Head of Midwifery at PTHB as soon as possible so that the internal processes for notifying senior leads within the organisation; and MBRRACE-UK are initiated, ensuring contact with the coroner throughout the investigation. The Head of Midwifery will then ensure the risk triggers are activated to commence an internal serious incident investigation if this is appropriate and ensure ongoing communication with the family.

The Woman's General Practitioner, Head of Midwifery or Governance and Risk Lead at PTHB will be responsible for reporting the death to MBBRACE-UK.

Each General Practice should ensure that all staff in the primary care team have access to and understand the procedure to be followed if a maternal death occurs, this is via the Trust internal website if required and all GP practices will be made aware of PTHB Guideline for managing a Maternal Death.

General Practitioners should also act to ensure that all staff working within their practice are aware of the processes related to identifying, alerting and investigating a maternal death.

8. Completing the MBBRACE Notification

Nominated leads for Maternity services have access to the MBBRACE-UK reporting system; these include the Clinical Lead, Deputy Clinical Director, Head of Midwifery and Risk Management Midwife

The Head of Midwifery (or nominated deputy) will be responsible for reporting a maternal death to MBRRACE.

Instructions for notifying are found in Appendices.

The records of the patient must be secured immediately, and a photocopy made of the handheld patient records and those held within the purple folder. In the case of a death in the community, a request must be made to the police for the

return to MEHT of the woman's handheld records to enable a full investigation to be completed.

9. Investigation Process

A DATIX will be completed, and an initial high level timeline will be discussed during the Incident Safety Huddle, the huddle will determine an investigating officer, terms of reference and timelines for the RCA that will be required.

The investigation report once completed and signed off will be shared with the staff involved and an offer to meet with the family will be made.

Consideration will be given to share the case at a learning event to share learning.

10. Monitoring Compliance / Audit

This policy will be monitored through clinical midwifery supervision, issues raised through training days and the Datix reporting system.

11. Review and Change Control

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

12. References / Bibliography

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 2018-2020 Nov 2022 Oxford

The tenth revision of the International Classification of Diseases, Injuries and Causes of Death, (ICD 10)

APPENDIX 1

Actions to be completed in the event of a Maternal Death

1. Inform Head of Midwifery, Head of Childrens Services,

2. Inform Director of Nursing & Midwifery.

3. Inform Clinical Supervisor for Midwives, Health Visitor and GP.

4. Maternal Death Co-coordinator/HoM nominates member of staff to support family who will ensure the family are signposted to others for advice on financial and emotional support that is available to them and their family members. Ensure the family are aware of investigation process, time scales and how this will be shared with them.

5. Commence Nationally Reportable Incident (NRI) investigation Patient Safety Framework. Initiate a round table discussion. Invites to HoS, Governance Lead, Director of Nursing & Midwifery, Quality & Safety, Safeguarding.

6. Staff support/counselling organised. Suggested debriefing before end of shift and then formal debrief meeting arranged. Offer additional support from 2wish.

7. Local Stillbirth/Neonatal death procedures initiated via MBRRACE.

8. Religious support arranged for family if required.

9. Ongoing communication and support for family to include support and advice for issues such as financial aid and support for other family members including children via school and health visitor network.

10. Liaison with Coroner and Mortuary.

11. Governance and Risk lead would record the maternal death in WPAS.

12. Health Visitor (team lead) would record the maternal death in WCCIS and close the record once all the information has been received.

13. Investigating officer to liaise with DGH for any input required from the services provided to the woman such as Obstetrics, Anaesthetics, Neurology.

APPENDIX 2

When a Baby dies with the mother

Definition of a Stillbirth

The definition of a still-birth as given in section 41 of the Births and Deaths Registration Act 1953 is: -

"Still-born child means a child which has issued forth from its mother after the twenty fourth (24+0) week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life, and the expression 'stillbirth' shall be construed accordingly".

If the birth occurred unattended and there was no lung aeration seen at Postmortem (PM) and no other circumstantial evidence of life at birth, it should be assumed that the baby was stillborn.

In all cases where there is evidence that the fetus has died prior to the 24th week of pregnancy, the death should not be notified as a stillbirth. Where there is any doubt about the gestational age at which the fetus died, the default position would be to notify as a stillbirth.

The act assumes that the mother is alive at the time of the still-birth. There is no provision to register a still-birth which occurs at the time of a post-mortem or at any time after the death of the mother. (General Register Office 1996)

Parental Responsibility

Where a child's parents were or have been married to each other at or after the time of conception, they each have responsibility for him/her - Section 2 (1), as extended by Section 1 of the Family Law Reform Act 1987, section 2 (3). Otherwise, the mother alone has parental responsibility, unless the father acquires it by a Court Order or an agreement under the Act (Section 2) or is named on the birth certificate.

Who else may acquire parental responsibility? - People other than parents may acquire parental responsibility by the private appointment of a guardian or an order of the court (a residence order, a care order, an emergency protection order, or an order appointing a guardian).

A guardian may be appointed to take over parental responsibility for a child when a parent with parental responsibility dies.

APPENDIX 3

Reportable Deaths: A Brief Guide

A death should be referred to HM Coroner if:

- The cause of death is unknown.
- It cannot readily be certified as being due to natural causes.
- The deceased was not attended by a doctor during her last illness or was not seen within the last 14 days or viewed after death.
- There are any suspicious circumstances or history of violence.
- The death may be due to an accident (whenever it occurred)
- There is any question of self-neglect or neglect by others.
- The death has occurred, or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station).
- The deceased was detained under the Mental Health Act.
- The death be due to an abortion.
- The death might have been contributed to by the actions of the deceased herself (such as a history of drug or solvent abuse, self-injury, or overdose).
- The death could be due to industrial disease or related in any way to the deceased's employment.
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred).
- The death may be related to a medical procedure or treatment whether invasive or not.
- The death may be due to lack of medical care.
- There are any other unusual or disturbing features to the case.
- The death occurs within 24 hours of admission to hospital (unless the admission was purely for terminal care).
- It may be wise to report any death where there is an allegation of medical mismanagement.
- This note is for guidance only; it is not exhaustive and in part may represent the desired local practice rather than the statutory requirements. If in any doubt, contact the coroner's office for further advice.

Tasks to be completed & Personnel to be notified	Completed by Date & Initials	Comments