Policy in the event of a Maternal Death

Speciality: Maternity

Approval body: Labour forum

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Contents

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 *Swansea Bay University Health Board (SBUHB)* 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 (Intrapartum 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?
If the death of a baby has occurred either by stillbirth or neonatal death a referral should be made to the Specialist Bereavement Midwife to provide dedicated support and advice regarding baby loss.

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

- Over 24 weeks gestation – it is not a legal requirement to register the death of a stillbirth. However, if the baby is delivered and an attempt has been made to save the baby and the baby then dies, it is to be registered as a neonatal death. Please follow guidance from the fetal loss, stillbirth and neonatal death guidance available on WISDOM

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.

6. Support for staff
The staff involved in the case will require both professional and personal support. The Midwifery Matron, line manager or Clinical Supervisor for Midwives may provide support for midwives, as well as the wellbeing at work team. It may be necessary to provide an experienced counsellor for staff as well as provide a timely debriefing session with staff involved on a group or individual basis. This can be arranged through the Care After Death team

The Care After Death team provide a bereavement support service for professionals. The team is available to support anyone that has been affected by death or bereavement across Swansea and Neath Port Talbot hospitals. Please see Appendix 2 for the referral process.

7. 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 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.		
On call Consultant Obstetrician:- • To meet/speak to relatives as soon as possible • To advise the next of kin and family the care after death team will make contact with them to inform them of referral to the medical examiner and/or coroner. The death certificate will need to be completed by the doctor, but only after the Medical Examiner has reviewed the case. The Doctor will be informed by the Care after death team when the medical examiner is ready to discuss the death with them. Only after the discussion with the medical examiner can the doctor complete the death certificate. A coroner referral can be completed and sent to the care after death team via email – SBU.CADC@wales.nhs.uk to be reviewed by the medical examiner.		
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 SBU HB Policy), respecting any religious beliefs.		
All adult deaths in acute hospitals in SBUHB are automatically referred to the care after death team. Complete referral form (Appendix 4 provides QR code or electronic form on (https://forms.office.com/r/dpbfntYtmn) to provide detailed information to team following the death.		
Letter providing contact details for the care after death team to be provided to family (Appendix 2)		
Provide next of kin and family booklet regarding care after death. (Available in Governance office, Level 4)		
Advise the relatives on when the body can be viewed in the Chapel of Rest.		
Ensure Lead Obstetrician is informed.		
Appoint a Midwifery Matron/Manager as point of contact for the family. Point of contact name :		
Local MBRRACE Co-ordinator (Lead Midwife for Quality, Safety and Risk or Intrapartum 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.		
Advise staff involved that witness statements will be required.		
If a student midwife 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). Datix ID:		

Notification to Welsh Government must be completed (National reportable incident – strategy meeting to be arranged within 3 working days).		
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.		

8. Procedure for sudden maternal death within 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 maternity unit matron or lead midwife for quality, safety and risk will provide initial advice and guidance for managing the death and will support completion of the above checklist where relevant. Out of hours, please contact the Manager on call for Maternity services through switchboard.

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 by the Police.

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.

5. The Lead Midwife or Matron is responsible for a referral to be made to the Care After Death time.

9. 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.
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 - Definitions

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 aggravated 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.

Maternity Services

Checklist for Clinical Guidelines being Submitted for Approval

Title of Guideline:	Policy in the Event of a Maternal Death
Name(s) of Author:	Kate Bannister – Lead Midwife for Quality, Safety and Risk
Chair of Group or Committee approving submission:	Labour Forum
Brief outline giving reasons for document being submitted for ratification	Updated Policy
Details of persons included in consultation process:	Maternity staff, Labour Ward Forum
Name of Pharmacist (mandatory if drugs involved):	N/A
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Date approved by Group:	February 2024
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Please indicate key words you wish to be linked to document	Maternal, death
File Name: Used to locate where file is stores on hard drive	