Maternal Death: Guidelines for the management of Maternal Death.

University Hospitals of Leicester NHS
NHS Trust

Trust ref: C2/2007

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1. Introduction and Who Guideline applies to

This guideline applies to all staff working within the Women's CMG, who may be involved in a maternal death during or within one year of pregnancy, childbirth, or abortion which is directly or indirectly related to these conditions.

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

Others staff 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, staff working within the Accident and Emergency department, staff working within the Intensive Care Unit and Pathology Consultants.

Background:

There is a statutory requirement to report all deaths of women or birthing people during or within 1 year of a pregnancy, irrespective of the nature of the pregnancy or the cause of the death. Maternal deaths may be considered as direct or indirect, as early (within 42 days) or late, and also as coincidental if unrelated to the pregnancy itself [(1)]. Direct/indirect maternal deaths are normally expressed as the number of women or birthing people who die from pregnancy-related causes while pregnant or within 42 days of pregnancy per 100,000 maternities. In the UK, maternal death is a rare occurrence, with the latest figures showing that around 9 in every 100,000 pregnant women or people in the UK will die from a direct/indirect cause within the first 6 weeks after pregnancy [(1)].

Maternal deaths have been subject to a national review for over 60 years. The Confidential Enquiry into Maternal Deaths' (CEMD) has represented a gold standard internationally for detailed investigation and improvement in maternity care and it recognises the importance of learning from every woman or birthing person's death, during or after pregnancy, not only for clinical staff and services but also for their family and friends [(1)]. The Enquiry reports have historically been published on a triennial basis but they are now reported annually by MBRRACE-UK to ensure key learning issues are disseminated as soon as possible.

Standard Statement:
UHL has a statutory responsibility to notify the Enquiry that a maternal death has occurred, and this guideline provides staff with the necessary information to achieve this. This guideline 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 UHL. It is important that staff 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.

This guideline does not replicate standard procedures to be followed following the death of an in-patient, but seeks to supplement them in relation to maternal death. This guideline does not address clinical issues that may exist prior to and after maternal death occurs.

Related documents;

- Last Offices Care of the Deceased UHL Policy
- Bereavement Support Services UHL Guideline
- Medical Examiners UHL Policy
- Learning from the Deaths of Patients Who Have Been in Our Care UHL Policy
- Deceased Urgent Certification and Release Outside Normal Hours UHL Policy
- Unexplained Intra or Postpartum Collapse UHL Obstetric Guideline
- Consent to Hospital Post Mortem Examination UHL Policy
- Spiritual Care UHL Policy

Definitions;

Maternal death is defined by the World Health Organisation as:

"Deaths of women while pregnant or within 42 days of delivery, miscarriage or termination 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 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 (fortuitous): Deaths from unrelated causes which happen to occur in pregnancy or the puerperium.

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 Women's Services, in other hospital departments, or in the community. If there is any doubt about whether a death needs reporting, the Women's Patient Safety team should be contacted for further advice (extensions 16424/15961/17625/15299)

2. Procedure should maternal death occur within maternity services

1) If not already present, medical and senior nursing / midwifery staff should be called.

2) The death should be verified 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:

4) The next of kin in this situation is usually the husband, partner or a blood relation

5) However, it is acceptable to inform whomever the deceased patient has documented as their next of kin in their maternity/medical records.

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

7) 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.

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

9) 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.

10) The 'Death Notice' must be completed, and the procedure for the death of an in-patient must be followed (see Appendix 1).

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

12) An experienced member of staff should be nominated to act as supporter to the patient's family and also act as their main point of contact to prevent conflicting information being given. This must be documented in the case notes.

13) The on-call Manager for Women's services should be informed in all cases where a maternal death occurs. Contact through switchboard.

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

15) The Head of Service should be informed when a maternal death occurs on the maternity unit even if it is out of hours – telephone **07814065007**

16) Maternal Death checklist must be completed in all cases (see Appendix 2).

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

18) The CMG Patient Safety team should be informed as soon as possible.

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

20) The CMG Patient Safety team will inform the Management team, who escalate to Trust Board level where necessary via the Corporate Patient Safety Team

2.1 Coordinator

One person should be nominated to ensure that all appropriate policies are followed. For the Women's CMG this will usually be the CMG Patient Safety Coordinator or Patient Safety Manager, in their absence. The UHL Bereavement team can provide advice and guidance (bereavementsupportservice@uhl-tr.nhs.uk).

The coordinator needs to make sure that all aspects of the maternal death checklist are considered, and completed where necessary. The coordinator may be released from their normal duties until this process is complete. The co-ordinator should not be the person who is in charge of co-ordinating the unit.

2.2 Death Certification and Coroners Referral

A doctor who has attended the patient in their 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 Trust by this doctor. The Medical Examiner 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, as guided by the Bereavement Services team. If 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, and a cremation form completed if applicable.

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 please refer to the Trust guideline [(3)]. The on call Medical Examiner can be contacted via the UHL Duty manager to authorise early release. Early release is not possible if a coroners referral is required.

2.3 Support for staff

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, professional midwifery advocates and occupational health staff.
Amica staff counselling and psychological support services are also available for all staff members along with local MDT debriefs and Trauma Risk Management support (TRiM).

Refer to Insite for up to date information on all staff support services.

2.4 Deaths outside maternity services

Any maternal death should be notified to midwifery bleep holder, who will notify on call consultant and Womens Patient Safety team. They will ensure that appropriate pathways are followed, depending on the circumstances of the death.

2.5 Deaths after 42 days

Notify Women's Patient Safety Team who will arrange appropriate notifications depending on circumstances.

2.6 Reporting to external agencies

All maternal deaths within 42 days of pregnancy, except those due to psychiatric causes, should be reported to the Maternity and Newborn Safety Investigations (MNSI) for an independent external investigation. The MNSI referral will be undertaken by the Women's Patient Safety team.

All maternal deaths within 1 year of pregnancy, irrespective of cause, should be notified to MBRRACE-UK, for inclusion in the national Maternal Confidential Enquiry into Maternal death. This notification is usually undertaken by the lead consultant for Perinatal Mortality, with the assistance of the Women's Patient Safety team.

3. Education and Training

None

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
All maternal deaths reported to MBRRACE who publish national learning every 3 years.	MIS	Risk team lead	Monthly	Women's Board MAC Mat Gov

5. Supporting References

1. Knight M, Bunch K, Felker A, Patel R, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2023
2. Medical Examiners UHL Policy Trust ref: B49/2017

3. Deceased Urgent Certification and Release Outside Normal Hours UHL Policy Trust ref: B12/2013

6. Key Words

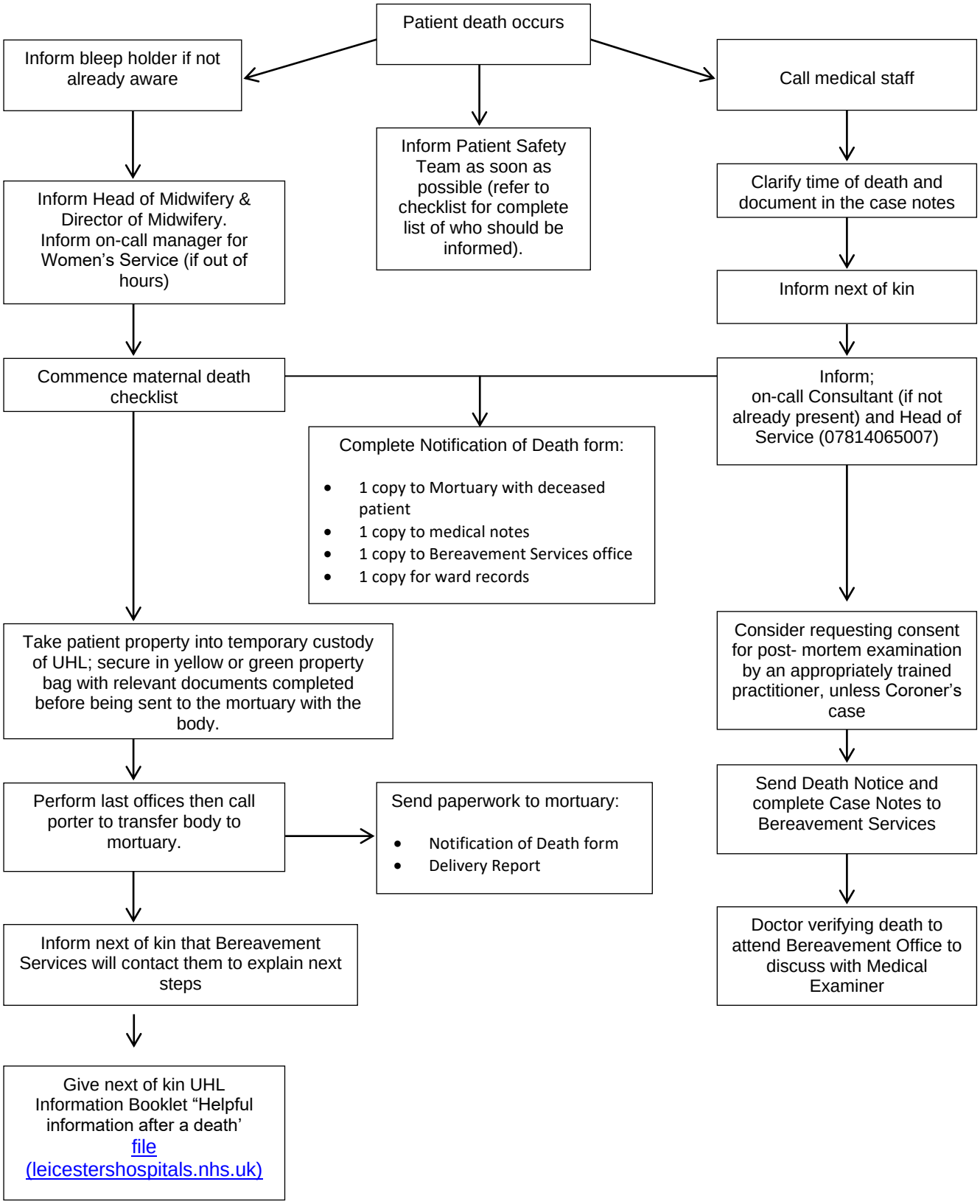
Maternal death, deceased, maternity, death certificate

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT		
Author / Lead Officer:	P Bosio	**Job Title:** Consultant Obstetrician
Reviewed by:	P McParland	

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
January 2013	2	N Savage	Changes to terminology ie MBRRACE and notification to on call CBU manager
January 2016	2	N Savage and P McParland	Background section updated and change for CBU to CMG, change of staff titles etc
May 2017	3	E Broughton, N Savage and L Matthews	Closure of Statutory Supervision
November 2020	4	Penny McParland	Background and Statistics updated. If any query about whether a death needs reporting to contact clinical risk and quality standards team (numbers provided). Next of kin may make a request for post-mortem caesarean section. This must be discussed with the Consultant on call removed. No longer required to inform PILS. Relevant hospital staff must be informed as soon as possible added in. Death Certification and Coroners Referral section, deaths outside of maternity, deaths after 42 days and reporting to external agencies added. Reformatted.
June 2024	5	Penny McParland Maternity guidelines group Maternity Governance Committee Women's Quality & Safety Board	Updated patient safety contact numbers. Added link to bereavement team mailbox. Added the Director of Midwifery to HoM regarding notification of maternal death. Clarified that the coordinator should not be the coordinator of the unit. Added PMA to the possible sources of support.

Appendix 1: Summary of action following maternal death within maternity services



Appendix 2: Maternal death checklist for Co-ordinator of case

(Document date when completed, who completed item and note where not applicable):

No:	Item:	Date:	By Whom:
1	Doctor to discuss with UHL Medical Examiner and issue Medical certificate of the cause of death (MCCD) if applicable		
2	Notify coroner only if advised to do so by Medical Examiner		
3	Inform immediately: ☐ Patient's Consultant (if not already present) ☐ Head of Midwifery ☐ Director of Midwifery ☐ Head of Service ☐ Matron of the day ☐ On Call Manager for Women's services (if out of hours)		
4	Inform as soon as possible: ☐ CMG Patient Safety team ☐ Bereavement Services ☐ General Practitioner ☐ Patient's Midwife ☐ Patient's Health Visitor ☐ Matron of the area ☐ Case holding student if applicable		
5	CMG Patient Safety team to notify: ☐ UHL Patient Safety team ☐ MBRRACE-UK		
7	Inform Safeguarding Midwife (if applicable dependent on individual circumstances)		
8	Follow the preparation of the deceased Adult (appendix 5) and other relevant sections of the UHL Last Offices and Care of the Deceased Patient Policy		
9	Send notes to obstetric secretaries to arrange follow up appointment for family		
10	If the patient was booked at another hospital, inform Consultant & Senior Midwife at that hospital.		

11	If death occurs outside the Directorate inform: ☐ Consultant for patient's current care ☐ Obstetric Consultant [In this case it is usually the GP who has responsibility for informing the local MBRRACE coordinator and the hospital if patient booked or receiving treatment there]		

NO PHOTOCOPIES OF THE CONFIDENTIAL ENQUIRY FORM (S) ARE TO BE MADE AT ANY TIME