Guidelines in the Event of a Maternal Death
- Full Clinical Guideline

Reference No.: UHDB/07:23/M2

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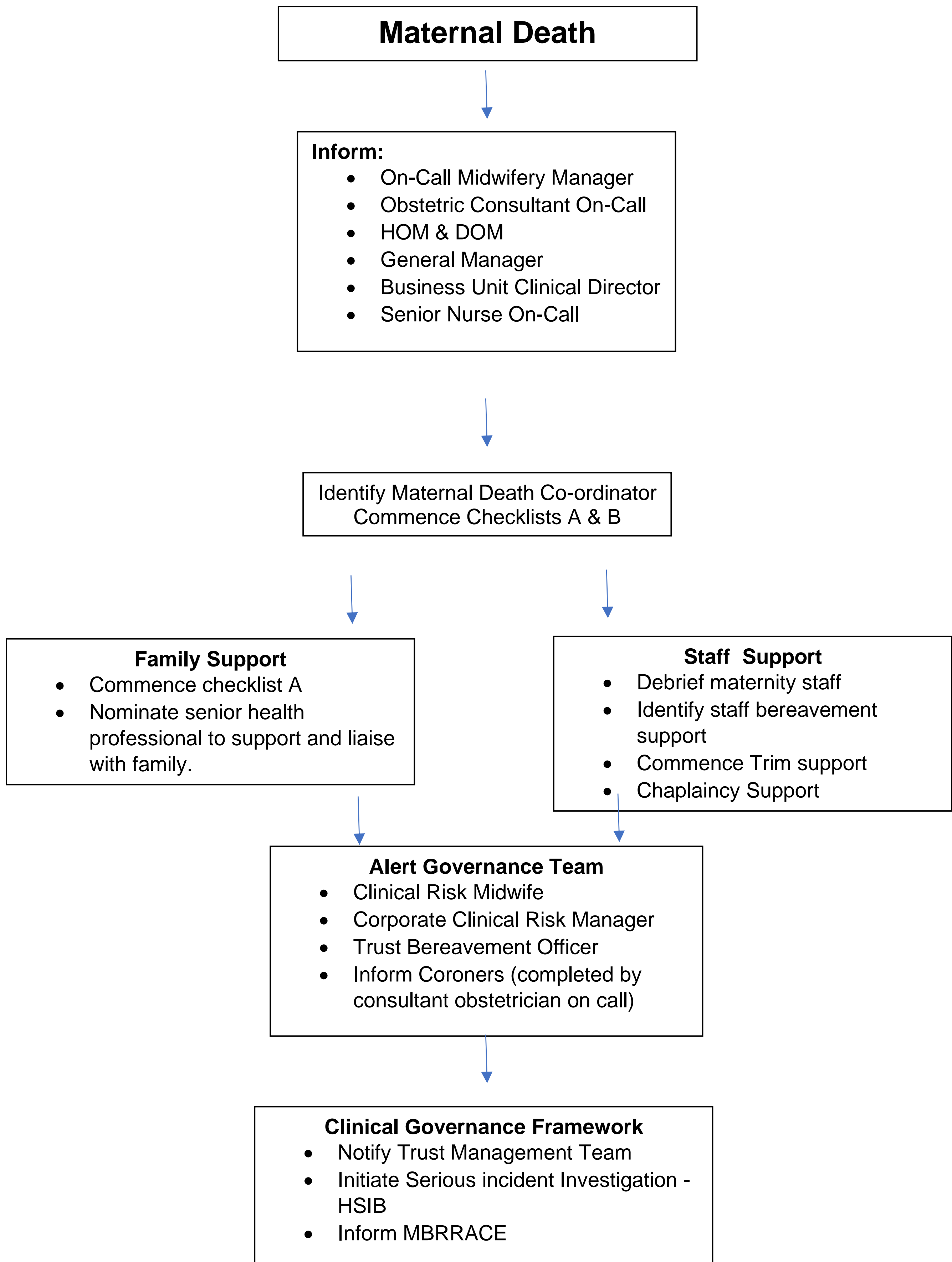
Maternal Death - Quick Reference Communication Pathway



1. Introduction

Overall, 247 women died in 2018-20 during or within 42 days of the end of pregnancy in the UK. The deaths of 18 women were classified as coincidental. Thus in this triennium 229 women died from direct and indirect causes, classified using ICD-MM (World Health Organisation 2012), among 2,101,829 maternities, a maternal death rate of 10.90 per 100,000 maternities (95% CI 9.53 – 12.40). This compares to the rate of 8.79 per 100,000 maternities (95% CI 7.58 – 10.12) in 2017-19 (rate ratio (RR) 1.24, 95% CI 1.02-1.51, p=0.028). Nine of the deaths which occurred between March and December 2020 were directly attributable to Covid-19 infection. If these nine deaths are excluded, the maternal mortality rate for 2018-20 would be 10.47 (95% CI 9.13 – 11.95) still higher than the rate for 2017-19 (RR 1.19 (95%CI 0.98 – 1.45), p=0.077) but no longer significantly so

2. Purpose and Outcomes

To provide guidance and support to staff following a Maternal Death and to ensure that the appropriate people have been notified in accordance with (MBRRACE)

3. Abbreviations

CD	-	Clinical Director
ACD	-	Associate Clinical Director
DOM	-	Director of Midwifery
HCP's	-	Health Care Professionals
HOM	-	Head of Midwifery
MAU	-	Medical Assessment Unit
MBRRACE	-	Mothers and Babies Reducing Risk through Audits and Confidential Enquiries
MOC	-	Manager on Call
ODP	-	Operation Department Practitioners
PMA	-	Professional Midwifery Advocate
RDH	-	Royal Derby Hospital

4. Definitions

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.

5. Managing a Maternal Death

The senior midwifery manager on-call (MOC) should be notified immediately. They will be responsible for initially co-ordinating the enquiry and ensuring that the family and staff are supported. The MOC will then be responsible for informing Obstetric Consultant on-call and the Head of Midwifery (HOM) and Director of Midwifery (DOM) as deemed appropriate.

It is important to note the names of all staff involved, particularly those staff that do not normally work with the Maternity Unit (i.e. Operation Department Practitioners (ODP) or crash teams, attending anesthetist).

In addition the CD, ACD and Clinical Director for O&G must also be notified at the next available opportunity.

If the death occurred in the maternity unit, the obstetric consultant on call or named consultant will be directly responsible for the management of the event and the consequences of the death.

The clinical risk midwife and Trust clinical risk manager should be notified when next on duty. They will liaise with the senior midwifery manager co-ordinating the enquiry.
Refer to checklist to ensure all procedures followed and that the appropriate HCP's and agencies have been informed.

The MOC and Consultant on call will be responsible for organising the continuation of the shift and assessing staff and work loads.

6. Last offices procedure and Transfer to Mortuary

See each site guideline:

For Burton:

https://derby.koha-ptfs.co.uk/cgi-bin/koha/tracklinks.pl?uri=http://derby.koha-ptfs.co.uk/cgi-bin/koha/opac-retrieve-file.pl?id=e006479998776b8908e681219975d255;biblionumber=2935

For Derby:

https://derby.koha-ptfs.co.uk/cgi-bin/koha/tracklinks.pl?uri=http://derby.koha-ptfs.co.uk/cgi-bin/koha/opac-retrieve-file.pl?id=43771de62ae346d95a37b52d516c2540;biblionumber=1935

7. Maternal Death and The Coroner

The Consultant Obstetrician should inform the Coroner and confirm that a post mortem examination is required. **It is likely that all maternal deaths will be a Coroner's case, in which case a post mortem must be carried out.** It is the duty of the Consultant Obstetrician to discuss the need for post mortem examination with the next of kin and this should be done in the presence of a midwife. In certain circumstances a coroner may authorise a post-mortem without the consent of the next of kin. In the event a maternal death has occurred and the woman goes directly to the mortuary and it is clear that the woman is pregnant the mortuary staff to notify the on-call obstetric team.

In the event of needing to register a birth/stillbirth please contact the bereavement midwifery team.

8. Family Support

In the case of a Direct death, the woman's family should meet the consultant on-call and bereavement team or, after discussion, the consultant of booking as soon as possible. Further meetings should be arranged for when the results of investigations are available in order for the findings to be comprehensively discussed with the woman's close relatives.

In the case of an indirect, late or coincidental death, the family should meet for a debrief with an appropriate Lead Clinician.

Specialist Bereavement Midwife may be used as a point of contact for the family if appropriate.

9. Onward Reporting

- If the woman has been admitted having been treated or booked in another hospital, the Head of Midwifery or Lead Obstetric Consultant of that hospital must be informed.
- The responsibility for notifying MBRRACE-UK that a maternal death has occurred should rest with either the obstetrician, senior midwifery manager, risk midwife or general practitioner who had overall responsibility for the pregnancy. If the death occurs within a year of the end of her pregnancy it may be the consultant or general practitioner who treated the woman during her final illness who is the identified lead.

10. Support For Staff Involved in the Care of the Woman

All staff involved in a maternal death should have access to support from their line manager, PMA and peer group. There should be an option to access occupational health for additional support or other outside agencies. The Specialist midwife for bereavement can also be accessed.

Good practice will see a TRIM debrief session arranged with all staff involved in the care of the woman, Lead Consultant and MOC of the incident and PMA, within one week of the death.

11. Monitoring Compliance and Effectiveness

As per Audit forward program

12. References

MBRRACE-UK: 2014 Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012

Royal Marsden Hospital Manual of Clinical Nursing Procedures. Last Offices 6th Edition intranet version - available on the Trust intranet (see short cuts on home page)

Confidential Enquiry into Maternal and Child Health (2011). Saving Mothers Lives 2006 -2008.

Nursing and Midwifery Council (2012), Midwives Rules and Standards. London: NMC

Appendix A

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Women's & Children's Services
Maternity

Maternal Death Checklist

AFFIX PATIENT STICKER
Name:

Hospital Number:

Address:

DOB:

TASK	RESPONSIBILITY	TIMING OF ACTION	DATE, TIME, SIGNATURE AND PRINT NAME
Contact Consultant on call	Shift co-ordinator or senior medical staff	Immediate	
Contact midwifery manager on call (On call if out of hours)	Shift co-ordinator	Immediate	
Contact Head of Midwifery & Director of Midwifery	Matron (Midwifery) Senior Nurse if Gynae	As soon a possible	
Contact named Consultant	Consultant on call	At first reasonable opportunity	
Refer case to MBRRACE-UK	Risk Midwife	At first reasonable opportunity	
Complete Coroner Referral form online	Consultant in attendance	Complete BEFORE telephoning coroner	
Notify Coroner's Office (see appendix for contact details)	Consultant in attendance	As soon as reasonably possible. Contact hours at weekends between 0900-1800 via switchboard	
Issue Death Certificate if applicable after discussion with Coroner	Consultant who attended the death	As per guidance of Coroner	

Contact Bereavement Services Royal Derby Hospital	Midwife/Nurse responsible for care	As soon as possible Extn: 85557 (answer phone available)	
Inform Mortuary that death has occurred and that a death certificate may not be available	Midwife/Nurse responsible for care	Before transfer to mortuary	
Photocopy and secure medical/maternity/nursing notes	Senior Matron/Nurse Gynaecology	At earliest opportunity	
Contact Social Services (SS) if family social circumstances are applicable If couple not married contact SS regarding parental responsibility issues	Shift co-ordinator	At earliest opportunity before family leave hospital	
Complete birth notification, stillbirth notification or neonatal death notification	Midwife responsible for care	At earliest opportunity	
Inform Community Midwife/General Practitioner/ Health Visitor Ensure appropriate care is arranged for live born baby.	Midwife responsible for care	At earliest opportunity	
Inform Clinical Director	Consultant in attendance	At first reasonable opportunity	
Inform Associate Clinical Director	Consultant in attendance	At first reasonable opportunity	
Ensure appropriate support available for all staff involved	Shift co-ordinator, Consultant in attendance, PMA	As appropriate	
Instigate risk management/ HSIB referral	Risk midwife	At first reasonable opportunity	
Ensure all outstanding appointments are cancelled for deceased. General/Medical/Maternity/Anaesthetic	Bareavement midwifery team	As soon as possible or next working day	
If deceased was transferred from another area. Consultant Obstetrician and Senior Midwife to be contacted	Senior Midwife Consultant Obstetrician	At first reasonable opportunity	
If the baby died. Complete MBRRACE on-line	Bereavement Midwife to complete	Within 7 days of death	

Appendix B

University Hospitals of Derby and Burton NHS Foundation Trust

Women's & Children's Services
Maternity

Maternal Death Checklist – before relatives leave the hospital

AFFIX PATIENT STICKER

Name:

Hospital Number:

Address:

DOB:

ACTION	COMMENTS	DATE, TIME, SIGNATURE AND PRINT NAME
Ensure appropriate care of partner and family members		
Do relatives wish to see deceased?		
Do relatives wish to see hospital chaplain or representative of their own faith?		
Has attending Consultant spoken with relatives		
Ensure deceased's property and valuables are given to relatives. Document items received and which family member received them		
Discuss whether any other relatives wish to see deceased and discuss appropriate viewing with mortuary staff		
Give relatives a copy of "practical guide about what to do when someone has died"		
Perform Last Offices (in accordance with the Royal Marsden Nursing Procedures 2004)		
DO NOT remove any prosthetics or medical articles/dressings e.g. venflon. ET Tube, Urinary catheter		
Cover all wounds with a dry dressing		
Complete Notice of Death form (wph0359) a) WHITE copy: attach to outer cover of deceased b) BLUE copy: to histopathology c) GREEN copy: file in notes		
If risk of infection see appropriate Trust policy and procedures for Infection Control		
Arrange for deceased to be taken to mortuary		

APPENDIX C

List of staff involved

Staff Name in full	Job title	Normal working area	Contact Email and phone number

Documentation Control

Reference Number: UHDB/07:23/M2	Version: **UHDB Version 2**		Status: Final	
	Royal Derby prior to merged document:			
Version / Amendment	Version	Date	Author	Reason
	1	Sept 2001	D Brookes (MW)	New guideline
	2	March 2004	S Appleby (HOM)	Review of guideline
	3	Nov 2010	S Rucklidge/ J Ryalls (Bereavement midwifery service)	Review and update of current guidelines
	4	Dec 2014	Jeanette Steward – Audit Co-ordinator S Rucklidge/ Bereavement midwife	Review & Update
WC/OG/19	**Burton Trust prior to merged document:**			
Original 2003	4	Jan 2018		Review & Update
Version control for UHDB merged document:				
	1	Feb 2020	Angela Thompson – Specialist Bereavement MW RDH Samantha Evans – Specialist bereavement MW Burton	Review & Merge
	2	May 2023	Midwifery Bereavement Team, matrons	3 yearly Review
Intended Recipients: All midwifery & Obstetric staff & A&E department/Trustwide				
Training and Dissemination: Cascaded electronically through lead sisters/midwives/doctors via NHS.net, Published on Intranet, Article in Business unit newsletter;				
To be read in conjunction with: Maternal Death Checklists				
Keywords:				
Consultation with:	Maternity Guideline Group, Miss Rajendran			
Business Unit sign off:	19/06/2023: Maternity Guidelines Group: Miss S Rajendran – Chair 19/06/2023: Maternity Governance Group - Mr R Deveraj			
Notification Overview sent to TIER 3 Divisional Quality Governance Operations & Performance: 20/06/2023				
Implementation date:	05/07/2023			
Review Date:	July 2026			
Key Contact:	Joanna Harrison-Engwell			