Document Control

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Maternal Death Guideline			
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1. Purpose

1.1. The purpose of this guideline is to assist healthcare professionals to ensure effective management in the rare event of a maternal death.

Health professionals who are involved in providing both primary and secondary care play an important role in participating in the on-going national confidential enquiries via MBRRACE-UK* (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) firstly by recognising that a maternal death has occurred, and secondly by ensuring that the appropriate people have been notified in order that an investigation can take place and any learning outcomes identified and disseminated throughout the Trust.

It is a statutory requirement that all health professionals provide information and participate in confidential enquires such as MBRRACE-UK which provides an overview of the numbers and causes of maternal deaths in the United Kingdom. The collated and anonymised information will highlight where improvements in clinical practice or service provision may help to prevent future deaths.

The aims of MBRRACE-UK are to provide robust information to support the delivery of safe, equitable, high quality, patient centred maternal, newborn and infant health services. The MBRRACE-UK is a secure web-based electronic data collection system which operates through the NHS N3 gateway.

The policy applies to all relevant Trust staff involved in a Maternal Death.

Implementation of this policy will ensure that:

- All staff involved in a Maternal Death have access to best practice guidance on the principles of managing a maternal death.

- **N.B. Health Records** It is vital that as soon as a maternal death is identified, the health records are located and maintained in a secure place and that the health records and any fetal monitoring including cardiotocographs/CTGs are scanned/photocopied.

2. Definitions

Maternal Death

The definition of maternal death is the death of a woman during pregnancy or up to one year after delivery. Women who die up to 42 days from delivery are those used in the international statistics (see table below). Women can die from direct causes related to pregnancy or from indirect causes such as pre-existing medical conditions, other illnesses and suicide, (MBRRACE, 2017)

Please see Appendix B for main causes of maternal death.

The following deaths should be reported, as soon as possible after the death has occurred to MBRRACE-UK including place of residence of the woman at the time of her death:

- All Direct maternal deaths: deaths during pregnancy or within 42 days of delivery, termination or abortion resulting from obstetric complications of the pregnancy state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above. The 42 day limit is an internationally recognised standard.

- All Indirect maternal deaths: deaths during pregnancy or within 42 days of delivery, termination or abortion resulting from previously existing disease, or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy e.g. cardiac disease.

- Coincidental (previously called Fortuitous) deaths: deaths during pregnancy or within 42 days of delivery, termination or abortion that occur from unrelated causes which happen to occur in the pregnancy, or puerperium, i.e. some malignancies, domestic violence, road traffic accidents, etc.

- In addition, the following deaths should be notified if they occur from 42 days to 12 months following delivery, termination or abortion:

- Direct deaths (see above)

- Indirect deaths e.g. peri-partum cardiomyopathy

- Deaths due to suicide

3. Responsibilities

Individual responsibilities set out in Section 4.

4. Managing a Maternal Death in Hospital

See Appendices A and B

Immediate Actions:

Contact (if not already present)

- Consultant Obstetrician (‘on call’ if out of hours)

- Lead Midwives ; Manager on call (‘on call’ if out of hours)

- Head of Midwifery (or Deputy in their absence)

- Clinical Site manager/Duty Manager and Executive on-call for North Devon District Hospital via bleep 500
- Inform relatives/next of kin if not present, allow relatives / ext of kin time with the deceased if they wish, however the body should be removed to the mortuary as soon as this is possible. Relatives/next of kin may then visit the mortuary to view.
- Offer to call chaplain/religious advisor as appropriate.
- Address (as appropriate).
- Care for the baby.
- Support for staff.

As soon as possible in office hours: cascade the information to the following:

- Consultant Obstetrician involved informs the Consultant in charge of the woman's care
- Inform the Associate Director of Operations, Clinical Support & Specialist Services Division
- Inform the Lead Clinician
- Clinical lead for Maternity Risk

The Senior Midwife will act as the co-ordinator and will inform:

- The Head of Midwifery
- Lead Midwife for area
- Clinical Risk lead
- Head of Quality and Safety
- Legal Affairs Manager

Health Records

Clinical Risk Manager or Lead Midwife or Manager on Call (if out of hours) will scan/photocopy the health records and CTG as soon after as is possible and store in a secure place (before the health records are sent to Bereavement Office or Coroner by the Pathologist until the post-mortem is completed).

Point of Contact

An experienced member of staff should be nominated to act as the main point of contact for the woman's family to prevent any conflicting information being given.

Consultant Obstetrician

It is good practice for the Consultant Obstetrician to notify the Coroner's Office of all maternal deaths and to document this in the health records and to advise the Coroner if:

- cause of death is unknown
- death has occurred during or shortly after an operation
- death had occurred before recovery from an anaesthetic
- death has occurred following an abortion
- death was unnatural or from violence or neglect

Clinical team;

Inform the Mortuary.

- See Trust policies for dying and bereaved, found on the Trust intranet (BOB). Carry out Last Offices (see policies for different cultures/religions and if it is to be a Coroner's case).

Any device must remain in situ e.g. urinary catheter, cannula, ET tube etc. Retain all equipment used in the resuscitation, noting the specific ID numbers of each piece of non-disposable equipment and (where possible) setting this equipment aside for review by appropriate staff before it is used again.

List property according to Property Policy

Complete and attach death notice and infection status label

Contact Bereavement Services

Give next of kin Trust bereavement leaflet/information/contact details

Ensure all documentation is completed as fully as possible

Report death on DATIX. This will initiate an internal 72 hour review and an external (HSIB) review of care

Inform GP and Health Visitor

Inform Team Midwife

Post Mortem

The Mortuary Department should be informed that a maternal death has occurred and to expect the patient. The Mortuary Attendant may inform the Pathologist on-call. If not, it will be the responsibility of the woman's (patient) named Consultant Obstetrician to do so. A post-mortem should be undertaken in order to confirm the cause of death.

The Consultant Obstetrician present should seek permission for a post-mortem from the woman's next of kin. If the cause of death is unknown, the Coroner is informed and he/she will be responsible for ordering a post-mortem.

Hospital Post-Mortem; A medical cause of death certificate has to be signed, based on the best available evidence, before a hospital post-mortem can be carried out.

Care of Baby

If the baby is born alive he/she should be cared for until he/she is fit for discharge and arrangements have been confirmed as to whom will care for him/her.

In the event of the baby dying in-utero, the following should be taken into consideration.

The baby is not defined as a stillbirth in this instance, even when removed from its dead mother at post-mortem. This is because the post-mortem is being carried out on the mother rather than the baby. Therefore, registration of a baby, in these circumstances over 24 week's gestation, as a death is not legally required. However, consideration must be shown to the wishes of the family.

A medical practitioner may issue a medical cause of death certificate for the dead baby, as stillborn.

As the majority of Pathologists will tend to remove the baby from the woman's uterus at post-mortem, it is sensible for the stillbirth/neonatal death procedure to be followed whether the baby is to be registered as a death or not.

The normal MBRRACE-UK alerting procedure should also be followed.

Support for the Family

There may be occasions when the next of kin or family may not be able to care for the baby and therefore contact should be made with Social Services with regards to a plan of care as soon as possible and document in the baby's health records. Until a plan is agreed liaise with the Special Care Baby Unit regarding caring for baby in the interim.

Safeguarding

If there are any concerns regarding safeguarding in relation to the circumstances of the woman's death and/or in relation to the baby's care, please inform the Named Midwife or Named Nurse for Safeguarding. For out of hours, contact the Duty Manager via bleep 500.

Notification of Maternal Death when a Woman is not Directly Receiving Maternity Care

Women whose deaths are classified as a 'maternal death' may not be directly receiving obstetric care as they may have been admitted to other areas in the Trust.

In these cases it is the responsibility of the other area/ward/division involved to ensure that the Head of Midwifery is aware of this event within 24 hours.

Reporting a Maternal Death to Regulatory Organisations

The Head of Midwifery; Risk Manager or Bereavement Midwife must contact MBRRACE as soon as possible. Ring 01865 289715 and leave a voicemail message with your contact details or alternatively email your contact details to MBRRACE – uk@npeu.ox.ac.uk.

COVID-19

Notification of maternal deaths of women with a positive COVID-19 infection is a PRIORITY. Please ensure that this death is notified to MBRRACE via 01865 0289715

Please also ensure that the medical records for this woman are sent as a priority electronically to: orh-tr.mbrrace@nhs.net.

Healthcare Safety Investigation Branch (HSIB)

The Risk Manager for Maternity must inform the Healthcare Safety Investigation Branch (HSIB) via their investigation Management System (IMS) and ensure a Datix is completed to escalate the investigation process. The Trust will perform a 72 hour review, HSIB will commence a serious investigation.

Support for Staff

Whether staff are directly involved or are a witness it is quite natural for them to experience a range of responses, including fear, shock, anger, panic, sadness and guilt. This is regardless of their age, role or experience.

Some people become as distressed by their response to the event as by the event itself.

It is recommended that the following are offered/ implemented as soon as possible:

Multidisciplinary Team Critical Incident Therapeutic De-brief

When a group of individuals are exposed to a frightening and perplexing situation, they can be affected psychologically in a number of ways. They might feel heightened anxiety, have re-occurring intrusive thoughts or sleep difficulties. They may feel impulses to avoid associated situations or have other reactions which are difficult to predict. A critical incident therapeutic debrief is a structured means of helping individuals who have shared such an experience.

The debriefing is facilitated by an individual who is properly trained in debriefing and has ample experience. A debriefing is a structured and yet flexible process which allows the group an opportunity to explore;

- What happened?
- How people think and feel about it?
- What they need for the future?

De-briefings are informal and therapeutic in design and intent; they are not related to incident reviews which may serve to investigate events and query an individual's response to difficulties.

De-briefings are confidential, and the facilitator will communicate with the referring manager to inform him/her that the debrief has occurred and who attended but no content is passed on.

It is often most therapeutic to hold a debriefing 2-5 days following the event.

Individuals may sometimes feel anxious about attending a debrief and that it may make things worse. This is rarely the case and it is helpful to the group that as many individuals who witnessed/participated in the event do attend.

To organise a debrief – contact Occupational Health on the Trust intranet:

https://ndht.ndevon.swest.nhs.uk/occupational-health/

Support for Midwives/Lead Clinicians/Consultants

Time should also be taken to specifically support the lead staff who managed the event.

Reflective Practice

Reflective practice sessions can be set up to review actions taken and lessons learnt, advise future practice and identify training and staff follow up requirements. A thorough investigation will automatically identify which members of staff will most benefit from reflective practice sessions.

Staff Counselling and Stress Management Service

The Trust offers a staff counselling and stress management service via Occupational Health (see above for contact details)

Counselling provides a place for people to explore and talk through any concerns with a trained professional. No experience is too trivial to warrant seeking help.

In addition Occupational health can offer stress management workshops to departments/departments.

5. Monitoring Compliance with and the Effectiveness of the Guideline

Standards/ Key Performance Indicators

Key performance indicators comprise:

- Review Reports to MBRRACE
- Review Serious Incidents Requiring Investigation Reports

Process for Implementation and Monitoring Compliance and Effectiveness

All maternal deaths are reported externally to MBRRACE and the Clinical Commissioning Group (CCG).

All maternal deaths are reported to Healthcare Safety Investigation Branch (HSIB) who are an independent agency who report all maternal deaths nationally. The completed report will be reviews/approved at the Trust Incident Report Group.

Any learning will be noted and monitored through the Maternity Specialist Governance Group (MSGG Equality Impact Assessment)

Group	Positive Impact	Negative Impact	No Impact	Comment
Age			X	
Disability			X	
Gender			X	
Gender Reassignment			X	
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership			X	
Pregnancy			X	
Maternity and Breastfeeding			X	
Race (ethnic origin)			X	
Religion (or belief)			X	
Sexual Orientation			X	

6. References

(Nov 2019) Saving Lives, Improving Mothers' Care Lessons Learned to Inform Maternity Care From the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17 Confidential Enquiry into Maternal and Child Health, RCOG Press, London

Accessed at MBRRACE-UK Saving Lives, Improving Mothers' Care, Lessons Learned to Inform Maternity Care

7. Associated Documentation

- Last Offices

APPENDIX A - Suggested contact list

Name	Contact number	Date and time notified	signature
Head of Midwifery (immediately)	Via labour ward		
Nominated HoM deputy	Via labour ward		
On-call senior midwife	Via labour ward		
On-call Consultant immediately (OOH)	Via labour ward/ switchboard		
Clinical site manager	Bleep 500		
Duty manager	Via Bleep 500		
Executive Director on call	Via switchboard		
On-call pathologist	Via switchboard		
Mortuary department	Via switchboard		
Bereavement Support Office	01271 322404		
Patients obstetric consultant (in hours)	Via switchboard or labour ward		
Patients GP	In maternity notes		
Patients Health Visitor	In maternity notes		
Patients community midwife	In maternity notes or via labour ward		
Coroner's office	Barnstaple 01271 335359		
Clinical Risk Manager	Office hours		
Director of Nursing	Office hours – via switchboard		
Any other allied specialty services ie drug liaison/ CPN/diabetes team	As per specialty		
Social services if required for safeguarding or care of baby			

Appendix B – Main Causes of Maternal Death