Maternal Death

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Departments/Group this Document applies to:	Maternity

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Guideline to be followed by (target staff): Staff involved in a maternal death

To be read in conjunction with the following documents:

Milton Keynes University Hospital NHS Foundation Trust. *Bereavement Policy (including after death care).* NUR/GL/29. Version 3.0, 2017.

Milton Keynes University Hospital NHS foundation Trust. *Incident reporting policy and procedure (including serious incident procedure).* RM/GL/17. Version 9.1, 2021

Milton Keynes Hospital University NHS Foundation Trust. *Stillbirth, termination of pregnancy and neonatal death after 24/40 gestation (care for) guideline.* MODW/GL/55. Version 15.3, 2021

Are there any eCARE implications?

CQC Fundamental standards:
Regulation 9 – person centered care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material lies solely with you as the medical practitioner.

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Guideline Statement

The purpose of this guideline is to assist the professionals working within the Trust following a maternal death to ensure that the appropriate processes, tasks, individuals have been notified and support is offered to the team directly involved. Mother and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) across the UK require that all deaths of pregnant Women/Birthing People and Women/Birthing People up to one-year following the end pregnancy (irrespective of place and circumstances of the death) to be reported to them.

This Guidance is to be used in conjunction with:
NURS/GL/29 Bereavement Policy – Including after death care. (Adult Patients Only)

Executive Summary

The UK's eighth MBRRACE – UK report (2021) reported that between 2017-19, 191 Women died during or up to six weeks after the end of pregnancy, from causes associated with their pregnancy, among 2,173,810 women giving birth in the UK.

8.8 Women per 100,000 died during pregnancy or up to six weeks after childbirth or the end of pregnancy. There is no statistically significant difference in maternal mortality compared to 2010-12.

Cardiac disease remains the largest single cause of maternal death, however, overall, there has statistically been a non-significant reduction in maternal deaths since MBRRACE reporting began. The Trust are committed to implementing continual change processes based on local and national drivers to support the introduction of multidisciplinary pathways to improve outcomes.

Definition

- **A Pregnancy – related death** is defined as deaths occurring in Women while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death.
- **A Direct maternal death** is defined as a death resulting from obstetric complications of the pregnant state (pregnancy, labour & puerperium), from interventions, omissions, treatment, or from a chain of events resulting from any of the above.
- **An Indirect maternal death** is defined as a death that results 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 physiological effects of pregnancy.
- **A Coincidental death** is defined as a death that occurs from unrelated causes which happens to occur in pregnancy or puerperium e.g. road traffic accident.
- **A Late death** is defined as a death that occurs between 42 days and one year after abortion, miscarriage or delivery that is due to direct or indirect maternal causes.

A maternal death may therefore include those Women who die following a miscarriage, termination of pregnancy, suicide from postnatal depression, death from cardiac disease or any medical disorder, ectopic pregnancy, following a surgical procedure and following a road traffic accident.

1.0 Roles and Responsibilities:

Head of Midwifery, Gynaecology and Paediatrics

- Ensure there is a guideline in place for the management of a maternal death which is in line with national guidance and legislation
- Ensure that there is a designated MBRRACE coordinator within maternity services
- Ensure all maternal deaths are reported to MBRRACE
- To provide support and guidance for the maternity team

Deputy Head of Midwifery

- To deputise for the Head of Midwifery, Gynaecology and Paediatrics
- To support the wider team as required.

Consultant Obstetricians

- Ensure that all medical staff are aware of their responsibilities
- Ensure that all medical staff involved in a maternal death have support
- Ensure all maternal deaths are reported to MBRRACE

Midwifery Team

- Provide support and information to the bereaved family.
- To be supported by the Labour Ward Coordinator to complete the necessary procedures and tasks required in the event of a maternal death.

Bereavement Midwife

- Provide support, information and advice to bereaved relatives.
- Signpost relatives to support services.
- Provide support and information to staff involved with a maternal death.

Professional Midwifery Advocates (PMA)

- Support and guidance for both the family and midwifery staff

Multi – Faith Chaplaincy Support

2.0 Implementation and dissemination of document

This guideline will be available on the Intranet.

3.0 Processes and procedures

3.1 Procedure following maternal death:

- Refer to check list (**see attached checklist appendix 1**) to ensure all necessary actions are taken and recorded.

- Prioritise the support and safety of all staff involved.

- Staff involved in the case will require support not only at the time of the maternal death but for some time after the event. Help is available through Professional Midwifery Advocates and TRIM trained practitioners.

- An appreciation for the pastoral care of family members of the woman and potential support required following the death should be taken into consideration - please refer to Trust Guideline NURS/GL/29 Bereavement Policy – Including after death care. (Adult Patients Only) for further information.

- The Woman's case notes need to be exported and loose papers photocopied, as the local MBRRACE coordinator will require a copy for the enquiry into the maternal death.

- The mortuary department are to be informed that a maternal death has occurred and to expect the Woman.

- In an unexpected death, the coroner should be informed via switchboard.

- If the cause of death is unknown or the death unexpected, the Coroner is informed. They will be responsible for ordering a postmortem. In certain circumstances the Coroner may authorise a post mortem without the consent of the next of kin. This process will be explained, to the next of kin, by the consultant. In situations where the coroner does not consider a postmortem is indicated the consultant will discuss the possible merits of a post mortem with the family and seek consent if requested.

- If the death of the Baby has also occurred the local MBRRACE coordinator must be notified of this as well. They will advise on the information that is required.

- In the event of the baby dying in utero the following should be noted: The definition of a stillbirth does not include the removal of a deceased baby from their Mother at postmortem for the purpose of ascertaining death. This is because the postmortem is being carried out on the mother rather than the baby. Therefore, in circumstances over 24 weeks gestation, registration of the baby is not legally required. However, consideration will be shown to family, explanations given and support offered with regards to funeral arrangements.

- If the baby has died in utero, but is born i.e. following a perimortem caesarean section, there should be a discussion with the coroner to ascertain if the coroner would like the baby to have a coroner's post-mortem. If no postmortem is requested by the coroner, then the next of kin should be contacted and offered a postmortem and/or cytogenetic testing on the baby. If postmortem is declined the placenta should still be sent for histological testing.

- Whenever a maternal death occurs a Radar incident form will be completed.
- Once the local MBRRACE co-ordinator has been notified she/he will liaise with the appropriate professionals.
- The enquiry form is supported by detailed guidance on how to complete. The information contained in these forms is collated and anonymised by MBRRACE, for publication in the triennial report on Maternal Deaths in the United Kingdom.
- In the event of a live birth, the initiation of the postnatal pathway in collaboration with the nominated neonatal care provider must be undertaken to ensure appropriate care of the newborn
- Referral to external professionals should be initiated as required, for example health visitor
- Consideration should be given to the emotional wellbeing of the neonatal care provider at the point of discharge and any supportive mechanisms required

4.0 Statement of evidence/references

Statement of evidence:

References:

Births and Deaths Registration Act 1953 (c.20) [online]. Available from: http://www.legislation.gov.uk/ukpga/Eliz2/1-2/20/contents (Accessed 15.03.2022)

Child Support, Pensions and Social Security Act 2000 (c.19) [online]. Available from: http://www.legislation.gov.uk/ukpga/2000/19/contents (Accessed 15.03.2022)

Children Act 1989 (c.41) [online]. Available from: http://www.legislation.gov.uk/ukpga/1989/41/contents (Accessed 15.03.2022)

The Deregulation (Still-Birth and Death Registration) Order 1996 (SI 1996/2395) [online]. Available from: http://www.legislation.gov.uk/uksi/1996/2395/contents/made (Accessed 15.03.2022)

Fairbairn, C. (2018) *Registration of stillbirth. House of Commons Library Briefing Paper Number 05595, 1 February 2018.* Available from: https://www.parliament.uk/documents/commons-library/Registration-of-stillbirth-SN05595.pdf (Accessed 15.03.2022)

Knight M, Bunch K, Tuffnell D, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK (2021) *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19.* Oxford: National Perinatal Epidemiology Unit, University of Oxford 2021 MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf (ox.ac.uk)

Milton Keynes Coroner's Office (2020). Circumstances when a death is reported. *Milton Keynes Council* [online]. Available from: https://www.milton-keynes.gov.uk/births-marriages-and-deaths/bereavement-services/hm-coroner-s-office/circumstances-when-a-death-is-reported (Accessed 15.03.2022)

5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
6.0	03/2022	Emma Mitchener – Deputy Head of Midwifery	Full review of the guideline.
5.0	02/2019		Executive Summary updated
4.3			Audit and monitoring criteria updated
4.0			References updated.
3.4			The following was deleted: **"**If the Coroner is happy with the cause of death and does not want the woman to have a post mortem then a death certificate can be issued." The following was an addition "If the Coroner is in agreement with the cause of death and does not want the woman to have a post mortem then a death certificate can be issued."

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Lauren Mitchell	Consultant Midwife	28.03.2022	28.03.2022	Comments regarding process and some grammatical changes.	Yes
Anja Johansen-Bibby	Obstetric Consultant	13.04.2022	14.04.2022	Comment surrounding legal definition regarding Mother, Baby and Stillborn	Yes

Melissa Davis	Midwifery	26.04.2022		Addition of context to the disturbance of the scene of death. Inclusion of importance of support for the family members. Inclusion of pastoral care of those family members and the provision of care in the event of a live birth. Inclusion of point in checklist.	

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Reporting to MBRRACE	MBRRACE Maternity Governance Processes		Every 3 years	

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women's and Child Health	Department	Maternity
Person completing the EqIA	Emma Mitchener	Contact No.	
Others involved:		Date of assessment:	Apr 2022
Existing policy/service	yes	New policy/service	

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	All staff caring for the woman and family

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?
Guideline group
How are the changes/amendments to the policies/services communicated?
Guideline monthly memo, intranet
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA			

Appendix 1: Checklist

Surname:
Forename:
DOB:
Hospital No:
Or affix Patient Label

Date and time of maternal death:

_____

Staff members to be notified:	Contact Number	Date and time notified	Signature
In and out of hours:			
Head of Midwifery or Designated Deputy Midwifery Manager on call Consultant on call Site Manager Silver Command	Via Switchboard		
Inform the Coroners Office	Via Switchboard		
Request for records to be exported from eCare and photocopy all loose paperwork including CTG;s and any ECG's. (once completed please hand the originals to the Maternity Governance Lead in hours or hand the originals to maternity manager on call)			
Contact at the earliest Opportunity (in hours):			
Chief Nurse Medical Director Executive on call	Via Switchboard		

Community Midwife Maternity Governance Lead Notify Lead Bereavement Midwife	Ext: 86484 Ext: 86034 Ext: 81757		
Communication with MBRRACE via the maternity governance team (to be reported within 7 days)			
Inform the Head of Midwifery at the Trust where the Woman/Birthing Person has booked (if applicable)	As per maternity notes		
Inform within the next 48hrs from the next working day:			
GP Health Visitor	As per medical record		
Inform Social Services if applicable	01908 253818 (in hours)		
Hot debrief for all staff involved with follow up after 72hrs with TRIM trained practitioner.			
If a student midwife has been involved in any aspect of care, please inform the Learning Environment Lead Midwife			
Inform the mortuary that the body may arrive without a death certificate (if referred to the coroner)			

If a postmortem has not been requested by the coroner then a discussion is to be had with the next of kin to offer post mortem and/or cytogenetics. Placenta to be sent for histology.			
Initiate postnatal care pathway in the event of a live birth			

Please complete the following paperwork

	Yes	No	Date
Death Certificate completed			
Death Certificate Issued			
Postmortem Consent			
All future appointments have been cancelled			
Record patients' property and give copy to relatives			
If jewellery left in situ – record details in notes Document on death notification form			
RADAR INC No:			