Frimley Health
NHS Foundation Trust

Maternal Death

Key Points

- Whilst maternal deaths are rare events, their consequences can be devastating for all involved; they can and may occur in either the community or the hospital setting.
- This guideline assists key individuals in ensuring the correct process and procedures are followed within the maternity service.
- This guideline assists key individuals in ensuring the correct process and procedures are followed if the death occurs in the community or outside of the maternity service.
- The correct individual and organisations are notified of a maternal death.
- Support for the family and relatives
- Support for Staff

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Abbreviations

CPN	Community Psychiatric Nurse
CTG	Cardiotocograph
DoM	Director of Midwifery
EAP	Employee Assistance Programme
ECG	Electrocephalograph
ET	Endotracheal
HV	Health Visitor
MBRRACE-UK	Mother and Babies: Reducing Risk through Audit across the UK
MNSI	Maternity and Neonatal Safety Investigation
PALS	Patient Advice and Liaison Service
PMA	Professional Midwifery Advocate

Contents

1. INTRODUCTION

Whilst maternal deaths are rare events, their consequences can be devastating for all involved; they can and may occur in either the community or the hospital setting.

Data on maternal deaths is collected by MBRRACE-UK (Mother and Babies: Reducing Risk through Audit across the UK)[1]. The MBBRACE-UK system is a secure web based electronic data collection system accessed by registered users only and complies with the National Information Governance Board.

In addition, maternal deaths both direct and indirect (excluding suicide) during pregnancy and up to 42 days of the end of the pregnancy are reportable to the Maternity and Newborn Safety Investigations (MNSI)[2].

A maternal death is defined internationally as a death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage, or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy[2].

A late maternal death is one which occurs more than six weeks but less than one year after the end of pregnancy.

Deaths can be further subdivided based on cause into:

- direct deaths, from pregnancy-specific causes such as pre-eclampsia.
- indirect deaths, from other medical conditions made worse by pregnancy such as cardiac or renal disease.
- or coincidental deaths, where the cause is considered to be unrelated to pregnancy, such as road traffic accidents3.

2. PURPOSE

This document provides guidance to ensure the effective management of a maternal death that occurs within Frimley Health Care NHS Foundation Trust. It should be noted that a maternal death may occur in any ward or department within the hospital or in the community.

3. ACCOUNTABILITIES AND RESPONSIBILITIES

For all staff to access, read, understand and follow this guidance.

Obstetricians and midwives:

- To use their professional judgement in application of this guideline.

Management/pathology and mortuary staff

- To ensure the guideline is reviewed as required in line with the Trust and national Guidelines.
- To ensure the guideline is accessible to all relevant staff.
- To monitor the audit process.

4. IMMEDIATE ACTIONS REQUIRED

First, inform the on-call senior midwifery manager and on call consultant obstetrician who will both attend and offer initial support to staff involved.

On call senior midwifery manager

- To determine whether the service is able to provide safe care to women in the immediate period and implement escalation policy, if applicable.
- Consider calling a second obstetric team including a consultant (who may not be officially on call) who can take over on call clinical duties.
- Call the site manager in the Trust.
- Instruct all staff that the scene of the death should remain undisturbed until advised by the coroner that it is acceptable to do so. This includes leaving the body undisturbed and not removing equipment such as ET tubes, intravenous lines and catheters.
- Confirm next of kin contact details and inform them if not present.
- Inform the Director of Midwifery (DOM) and the Head of Midwifery (HOM) for the site, who has the overall responsibility for maternal deaths occurring in hospital and will act as a coordinator or who will delegate coordination responsibilities. This individual must notify the on-call director for the Trust.
- Act as co-ordinator and commence the check list (Appendix 1).

On call consultant obstetrician

- Inform Chief of Service.
- Inform consultant anaesthetist on call or if during day lead for obstetric anaesthetics.
- Liaise directly with the coroner.
- Communicate any immediate actions required on behalf of the coroner.
- Inform the next of kin.
- Meet the relatives as soon as possible.
- Seek consent from the woman's next-of-kin for postmortem.
- It is the responsibility of the consultant to inform the on-call pathologist to ensure the postmortem is undertaken by an appropriate specialist pathologist.

The following may require action:

- Swabs and blood samples should be taken as medically directed.
- Check whether there are spiritual or cultural considerations for the family.
- Perform last offices if the coroner has agreed this can be undertaken. Seek support from gynaecology matron regarding performing last offices.
- Update EPIC with outcome as deceased. The patient safety team in communication with Information Governance will arrange for notes to be sent to following agencies, Coroner, MNSI and MBRRACE.
- Complete incident report.
- Inform mortuary that a maternal death has occurred and to expect the body.
- Assign a named midwife to the woman's family (usually the on-call midwifery manager or matron level or above).

5. SUBSEQUENT ACTIONS

(if not feasible on the day, then the next day)

Head of midwifery or delegated lead to be maternal death coordinate to inform:

- G.P.
- Named lead midwife – should be told in person, do not leave a message;
- Woman's named obstetric consultant – should be told in person, do not leave a message;
- Associate director for women and children's services;
- Medical director;
- Chief of Nursing and Midwifery;
- Trust legal representative;
- Trust media lead;
- Chief executive;
- Health visitor;
- Midwifery matrons;
- Professional Midwifery Advocate team (PMA);
- Consider contacting the hospital chaplain via switchboard for either family or staff or both.

Head of midwifery

- Facilitate a meeting between obstetric consultant and relatives;
- Staff support - offer occupational health support, counsellor support and PMA support;
- Ensure a midwifery manager/Trust coordinator is appointed to liaise with the family;
- Arrange a multi-disciplinary debriefing.

Patient safety team

- Request statements from those staff involved - staff must complete these independently of each other;
- Serious incident and 72-hour report are completed;
- MBRRACE notification;
- MNSI reporting;
- Arrange for EPIC records to be closed and shared with agencies listed above.

Midwifery manager

Should be appointed to liaise with the family and ensure the following are discussed with the relatives:

- The need for postmortem;
- The death certificate;
- Collection of property;
- Appointment with woman's obstetric consultant and/or consultant responsible for the woman's care;
- Provision of support and care for baby.

In the event of the baby dying in the uterus, the following should be taken into consideration. *This advice has been given by the Registrar General (Office for National Statistics)[4].*

- If the baby was removed either alive or stillborn in attempt to save the mother's life, the baby is required to be appropriately registered.

- If the mother is pronounced dead and the baby remains in utero, the removal of the baby should be undertaken by the pathologist who will tend to remove the baby from the mother's body at post-mortem. It is sensible for the local stillbirth/neonatal death procedure to be followed whether the baby is to be registered as a death or not.

- It is a decision for the medical team to issue a stillbirth certificate for babies that are over 24 weeks gestation. Discussion and agreement of this requires sign off from consultant obstetrician and should consider the woman's partner and family wishes as this is not a legal requirement.

- The bereavement team will act as liaison with the family should they request photos, hand and footprints.

When a woman dies unexpectedly in another part of the hospital or community

If a woman dies outside of the maternity service, e.g., ITU, emergency department, radiology, theatres, etc., the on call obstetric consultant and the senior midwifery manager for that site should be informed as soon as possible.

If the death occurs shortly after admission without the prior involvement of maternity staff, then the maternity team need to be involved at the earliest opportunity and the on-call consultant and senior on call maternity manager should be informed. Advice should also be sought from the site coordinator in relation to the most appropriate place for last offices to be performed.

For women who have been on the ICU for a period of time, the maternity and/or gynaecology team should already be involved in the woman's continuing care and should be informed about the woman's death as a matter of routine.

When a maternal death occurs in early pregnancy, or a pregnant woman collapses in the community and is brought to the emergency department, maternity and gynaecology personnel may not be involved in the immediate care. Nevertheless, all staff should be encouraged to seek advice from maternity unit, the on-call consultant, the head of midwifery or out of hours the senior on call maternity manager contactable via switchboard. To ensure the correct processes in relation to a maternal death are followed.

If the woman has been referred to another hospital for specialist care

Where admission for care has been to another hospital, for example, for specialist care, it is important that the referring and booking teams are kept informed of the woman's progress and death when it occurs, especially if the baby is still at the referring hospital. The referring hospital will need to co-ordinate the future care of the baby (if the baby is still under their care), the case review and the investigation if one is required, as well as family and staff support.

Anticipated Death

In women with significant pre-existing morbidity where death is a possibility, a plan should be put in place regarding who should be informed in the event the woman dies. Measures to support the partner and family may already be in place for such anticipated deaths, but where they are not these should not differ from the actions following an unanticipated death and bereavement care should be initiated early.

Postmortem and Death Certificate

The On Call Obstetric Consultant must ensure that they or a deputy discuss all maternal deaths with the coroner within the first 24 hours of the death. It is important to agree which member of staff will have this discussion. If the death has occurred outside the maternity unit the Medical team or examiner must speak with the On Call Obstetric Consultant before they speak to the coroner.

If the death has been anticipated for some time a postmortem may not be required, although it may be prudent to discuss the death with the coroner. In these cases, the On Call Obstetric Consultant must be contacted.

If a coronial requested postmortem is not going to be carried out, the option of a hospital postmortem should be discussed and offered to the next of kin as their consent will be required.

Staff wellbeing

Senior midwifery manager will ensure that staff are supported by consultant/educational supervisor, manager, PMA, occupational health referral if required.

In addition, the Trust provide the following support for all staff:

Frimley Health Helpline – for psychological, wellbeing and pastoral support 24/7, provided by Employee Assistance Programme (EAP) Provided by Health Assured **0800 028 0199** https://www.healthassured.org/

National NHS Helpline for all staff for mental health, financial health, bereavement care and coaching. Phone **0300 131 7000** (7am – 11am daily) or text Frontline to **85258**

REFERENCES

1. MBRRACE-UK (2022) *Saving lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-2020*.
   Available at: https://www.npeu.ox.ac.uk/mbrrace-uk/reports (Accessed: 27 September 2023).

2. Maternity & Newborn Safety Investigations:
   Available at https://www.mnsi.org.uk (Accessed 27 February 2024).

3. World Health Organisation (2022) *International Classification of Diseases*. 11th ed.
   Available at: https://www.who.int/standards/classifications/classification-of-diseases (Accessed: 27 September 2023).

4. *The Registration of Births and Deaths Regulations 1987 (SI1987/2088)*. Available at: https://www.legislation.gov.uk/uksi/1987/2088/contents (Accessed: 27 September 2023).

5. Royal College of Obstetricians and Gynaecologists. (RCOG) *Managing Events Surrounding a Maternal Death and Supporting the Family and Staff.* Available at: 18-maternal-death-final-publication-proof.pdf (rcog.org.uk) (Accessed 27 February 2024)

APPENDIX 1: MATERNAL DEATH CHECKLIST FOR STAFF

Maternal Death checklist for staff

(To be completed and attached to the Maternal Records)

Date:
Addressograph label or
Name:
Address:
DOB:
NHS number:

Notify Immediately

	Name of Individual Notified	Date & Time	Signed
Next of Kin			
Obstetric Consultant on call			
Midwifery Manager on Call			
Chief of Service			
Director of Midwifery			
Head of Midwifery			
Trust Site Coordinator OOH			
Hospital chaplain (if appropriate)			

Notify in Office Hours: (Women & Children's Directorate)

	Name of Individual Notified	Date & Time	Signed
Associate Director of Women and Children's services			
Named Obstetrician in women's care if applicable			
Community Midwife responsible for woman's care			
Maternity Patient Safety Team			
Maternity Matrons			
Bereavement midwives			
Counsellor in maternity			

Hospital Management

	Name of Individual Notified	Date	Signed
Chief Executive			
Chief Nurse			
Legal/Risk Manager			

Other Health Professionals

	Date	Signed
GP – name:		
HV – name:		
Ensure Coroner's office has been informed		
Ultrasound Dept.		
Cancel all hospital appointments		

Others

PALS		
MBRRACE – UK www.npeu.ox.ac.uk/mbrrace-uk		
MNSI		
Trust Media Lead		
Any other professional who may have been involved, e.g., social worker, CPN, substance misuse service, children centres. Please list all those informed		

APPENDIX 2: MATERNAL DEATH CHECK LIST – ON CALL MIDWIFERY MANAGER / MATERNAL DEATH COORDINATOR

Maternal Death Check List – On call Midwifery Manager/Maternal Death Coordinator

(To be completed and attached to the maternal records)

Date:
Addressograph label or
Name:
Address:
DOB:
NHS number:

	Action	Date	Time	Signature
1	Ensure that Maternal checklist for staff (Appendix 1) has been completed			
2	Secure and close maternal records on EPIC at the earliest opportunity. This includes CTG and ECG if applicable.			
3	Nominate a member of staff to compile a list of all staff present and those who gave care preceding the death			
4	Nominate a member of staff to support relatives of the deceased			
5	Nominate a PMA to support other staff and arrange a debriefing for all on duty			
6	Ensure the death certificate is promptly and accurately completed by the consultant. It is appropriate for the relatives to deliver the certificate to the Registrar of Births and Deaths			
7	If the woman has been admitted having been treated or booked in another area, the senior midwife and consultant at that hospital must be informed			
8	Other health professionals/ key workers involved with the woman should be informed e.g. consultant anaesthetist, CPN, substance misuse services. Social services should be notified if the family social circumstances are applicable, or if a live baby requires care and the family support			
9	If the death of the baby has occurred, the MBRRACE – UK notification of perinatal death form should be completed on line at www.npeu.ox.ac.uk/mbrrace-uk			

APPENDIX 3: MATERNAL DEATH INFORMATION FOR STAFF CARING FOR WOMEN NOT RECEIVING DIRECT MATERNITY CARE

A maternal death is defined as the death of a woman while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. (World Health Organisation 2010)

In the rare event of a maternal death occurring within your department please inform the on call Obstetric Consultant and Head of Midwifery (out of hours the senior on call maternity manager) via switch board at the earliest convenience. They will be able to assist with the notification process, discussions with the coroner, support for the family and care for the baby (living or deceased)

Please note the following information will be required.

- Ward / department:
- Woman's Name:
- Address:
- DOB:
- NHS number:

Date of Death

Have the next of kin been informed – yes / no

Gestation of pregnancy (if known / relevant):

Date of delivery / age of baby (if known / relevant):

Coroner Informed

Cause of death (if known):

Summary of recent care:

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This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1	Dec 2016	Labour ward matron FPH Lead midwife for clinical governance cross site	Final	First cross site version
2	Sept 20	Director and Heads of Midwifery	Final	Updated and approved at OGCGC
3	Nov 2023	Director of Midwifery and Heads of Midwifery	Final	Scheduled review. Ratified at Obstetric Clinical Governance Committee 21.11.2023
4	March 2024	Director of Midwifery	Final	Approved at Cross Site Clinical Governance Meeting 27.03.2024

Related Documents

None