Guideline for the management of a maternal death

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In this guideline we use the term 'woman' throughout. This should be taken to include people who do not identify as women but are pregnant.

1.0 Introduction

Maternal deaths in the UK are rare but require careful and sensitive management when they occur. It is important to recognise the personal tragedy, sadness and grief for the family but also the impact on staff who are unlikely to be experienced in giving care in these circumstances.

2.0 Objective

The aim of the guideline is to assist professionals in ensuring effective management in the rare event of a maternal death. This guideline details the immediate actions to be taken following a maternal death. It is intended to assist professional's office within the Trust to ensure that the appropriate people and agencies have been notified, the correct processes have been initiated and also identify the support mechanisms and avenues for ongoing communication for the family and the staff involved.

3.0 Scope

This guideline applies to all staff caring for a woman and her family following a maternal death. This may include:

- Chaplaincy Department
- Bereavement Officers
- Pathology and Mortuary staff
- Site matron and trust on call team
- Maternity manager on call

4.0 Actions to be taken following a maternal death

4.1 Immediate actions

The Obstetric Consultant and Maternity Manager on call should be asked to attend, if not already present. The Site Matron must also be informed and both silver and gold on-call. In office hours, the Head of Midwifery (HoM) or Deputy Associate Director of Midwifery/ (DHoM) must always be informed.

The Obstetric Consultant will assist in the completion of any clinical procedures in progress e.g. caesarean section.

It must be determined whether the service is able to provide safe care to other women in the immediate time following the maternal death as it is likely to be unexpected. Input from the full multidisciplinary team (MDT) will be required. If necessary, the escalation policy should be initiated.

When a maternal death occurs, if not already present, the next of kin must be informed. This duty must be undertaken by the Maternity Manager on call, Consultant Obstetrician or Trust Silver on call.

The Mortuary department should be informed that a maternal death has occurred and to expect the patient.

The Patient Relatives Officer must be made aware of the death by telephone (Ext 1393). They will require the patient's name, date of birth and next of kin contact details. The Patient Relatives Officer will then inform the Medical Examiner's office of the death via a paper diary.

In hours, the Obstetric Consultant together with the HoM or DHoM will meet with the relatives. Out of hours, the Obstetric Consultant on call will be accompanied by the Maternity Manager on call, to answer any immediate questions. In very urgent circumstances out of hours the Birthing Centre Co-ordinator will accompany the Obstetric Consultant to talk to relatives. If activity on the labour ward is high and the Birthing centre Co-ordinator is unavailable asking the Site Matron to support until the Maternity Manager on call is on site may be the appropriate action to take.

Verbal duty of candour can be undertaken at this point. If the woman already has a named Consultant, they should be informed by the Consultant on call at the earliest opportunity.

Post Mortem

The Obstetric Consultant present should explain to the woman's next of kin that the death will be referred to the coroner. The coroner will then decide if a post mortem is required. It should be explained to the family that if a post mortem is necessary, it does not require permission from the next of kin.

Nationally all maternal post-mortem examinations must be conducted by pathologist who is an expert in maternal physiology and pregnancy related pathologies.

Coroners

The Medical Examiner's office will obtain the patient records, review the medical notes and speak to the medical team involved in the patient's care. If a coroner's referral is required, the obstetric medical staff must inform the coroner by email via BarnsleyCoroners@sheffield.gov.uk. The Medical Examiner's office will provide the medical staff with a template to use for the referral. The medical Examiner's office must be copied in to the email (barnsley.medicalexaminersservice@nhs.net)

Death Certificate

The Medical Examiner's office will speak with the family and explain the cause of death. The attending doctor must promptly and accurately complete a death certificate. However, a death certificate cannot be issued without first referring to HM Coroner.

Once the death certificate has been completed the Patient Relatives Officer will send the completed certificate to the Registrar at the town hall.

4.1.2 Death occurring in the trust, outside of the maternity unit

If a maternal death occurs in a Trust department other than maternity e.g. ED or ITU then the Consultant responsible for the patient must ensure that the Consultant Obstetrician; Maternity Manager; Site Matron; Silver and Gold on call are notified.

4.2 Notification of death

Members to be notified after the event:

1. If not already present, the Maternity Manager on call will be asked to attend, alongside the obstetric consultant on call to assist with managing the situation and providing support to the staff involved.
2. The Associate Director of Midwifery/ (HOM), or deputy in the absence of the HOM, should be contacted as soon as possible after the event in office hours and immediately if the event takes place in office hours.
3. The Maternity Matron will be notified within office hours by the coordinator or Maternity Manager on call.
4. The Lead Obstetrician and the Clinical Director must be contacted as soon as possible by the on-call consultant Obstetrician and always if the event takes place in office hours.
5. The Associate Director of Midwifery, or Deputy Associate Director of Midwifery, will inform the Director (or deputy) of Nursing and Quality, CEO and Head of Governance within office hours.
6. The Lead Midwife for Quality, Safety and Governance will be informed as soon as possible within office hours.
7. Clinical managers within the Department should be notified; in case they receive a query in relation to the case.
8. If applicable, the community midwife/midwives who were involved in the woman's care should be notified when next office.
9. The College Tutor and relevant Educational Supervisor should be informed to provide support for any trainees involved as required. The relevant University will be informed if any students are involved in the care of the mother who has died.
10. The woman's GP and Health Visitor should be notified the next office day.
11. Any other consultants providing care during the pregnancy e.g. diabetic specialist should also be informed.
12. The Neonatal team, as appropriate.

4.3 Last Offices

Please refer to the Trust last offices guidelines Care of an adult patient following death.pdf (trent.nhs.uk)

5.0 Responsibility for Reporting a Maternal Death

5.1 Maternity Governance

A maternal death should be reported as soon as possible via the Incident reporting incident reporting system. Staff are encouraged to undertake a SWARM with the multidisciplinary team of the care to identify any immediate learning with the staff involved in line with the SWARM policy.

The Maternity Governance team will arrange and facilitate a rapid review meeting in line with the never event management process

The incident will be presented at the Patient Safety Panel (PSP) via a compiled timeline of events.

The Director of Nursing will inform the Chief Midwifery Officer, CQC and ICB Lead Nurse of the maternal Death.

The Governance Team will notify Maternity and Neonatal Safety Investigation (MNSI) and the Local Maternity and Neonatal System (LMNS) following the PSP meeting. If a joint panel is deemed required by PSP/ the weekly incident review meeting the governance team will liaise with the LMNS to facilitate this within 7 working days of the meeting.

Following the review of the care, the incident will be referred to the MNSI for investigation. If MNSI do not investigate the incident this will be discussed at PSP to discuss if any other investigation route required.

The Maternity Digital Team will be responsible for checking internal systems to review and cancel any forthcoming appointments the deceased had recorded.

Duty of Candour will be completed in line with the Trust policy.

5.2 Reporting to MBRRACE

The responsibility for notifying the death to MBRRACE lies with the MBRRACE Lead Clinician. If the death of the baby has also occurred the local MBRRACE Lead Clinician must be notified of this. They will advise on information that is required and next steps.

5.2.1 Responsibilities of the MBRRACE Lead Clinician and team

- When the MBRRACE lead clinician is informed of a maternal death they will contact MBRRACE head office by telephone (01865 289715) to request a confidential enquiry form within two office days.
- In their absence the Governance Midwife can request the form. The MBRRACE lead clinician will complete the enquiry form providing contact details for the relevant clinicians within 2 weeks.

- The governance team will send a copy of the medical records to MBRRACE within the allocated timescale following approval by the Medical Director and Director of Nursing.
- MBRRACE will contact the relevant clinicians requesting further information on the case.
- The Governance Midwife will coordinate collecting the completed MBRRACE forms from the relevant clinicians and gain approval by the Medical Director and Director of Nursing prior to sending these to MBRRACE.

5.3 Registration of the birth of a baby in the event of a maternal death

If there is a live baby then appropriate ongoing care for the new born infant should be established. A family centred MDT approach to discharge is required. The Named Safeguarding Midwife, the woman's community midwife and social services should be involved in the care planning prior to discharge.

Regarding Parental Responsibility, in accordance with the Children Act 1989 c.41 Part 1 Section 2:

- If the couple are married the father automatically assumes parental responsibility
- If the couple are **not** married the father does not have parental responsibility unless he is named on the birth certificate
- If the father does **not** have parental responsibility the baby must **not** be discharged home to his care or the care of any other family member as they do **not** have parental responsibility

- If the couple are in a same sex relationship all of the above applies to the civil partner

5.4 Fetal/Neonatal death

In the event of the death of the baby, the local stillbirth/neonatal death procedure should be followed as per local guidance.

In the event that the baby dies in utero when the mother dies, the baby will be examined at post mortem if requested by the coroner or relatives.

5.5 Bereavement Services

The Patient Relatives Officer will contact the family to explain the process regarding the coroners and the death certificate.

The specialist bereavement midwife may act (if the family wishes) as a point of contact with maternity services and offer advice and support with the ongoing processes such as registering the death, release of the body from hospital, arrangements relating to post mortems and the coroner.

6.0 Roles and responsibilities

6.1 Birthing Centre Co-ordinator
Offer immediate support to staff and the family. Notify all relevant parties as per the instructions in this guideline.

6.2 Obstetric Consultant on call
Offer immediate support to staff and the family. Complete any ongoing clinical procedures. Inform the next of kin and explain referral to the coroner. Complete verbal duty of candour as per trust policy.

6.3 Attending Doctor
Offer support to the family. Refer to the coroner as per the instructions in this guideline. Complete the death certificate.

6.4 Maternity Manager on Call
Offer immediate support to staff and the family. Alongside the Obstetric Consultant inform the next of kin.

6.5 Associate Director of Midwifery//Deputy Associate Director of Midwifery/ Offer support to staff and the family

6.6 Patient Relatives Officer
Obtain the patient details including the next of kin contact details and share this information via a paper diary with the Medical Examiner's office. Contact the family and discuss the coroners and death certificate process. Send the death certificate to the registrar at the town hall.

6.7 Medical Examiner's Office
Obtain the medical records for the patient and scrutinise the notes for the cause of death. Speak with the medical team involved to agree the cause of death. Advise the medical team regarding making a referral to the coroner and share a template to use. Speak with the family to explain the cause of death.

6.8 Named Consultant
Completion of the MBRRACE forms as patient lead consultant.

6.9 Obstetric Clinical Lead
Review form prior to submission to the Director of Nursing.

6.10 Site Matron
Offer immediate support to staff and the family.

6.11 Silver on call
Offer immediate support to staff and the family.

6.12 ICU/ED on call consultant
Completion of the MBRRACE forms if identified and provided staff support where needed

6.13 Occupational Health
Support staff in line with policy

6.14 Subject access team
Collocate all the patient records and share with the governance team

7.0 Support

Family
Following a maternal death, the family should be offered condolences and receive a debrief as soon as clinically appropriate. The consultant will seek to establish open lines of communication with the family and offer follow up appointments. The relatives must be given the opportunity to ask any questions. The contact details of the specialist Bereavement Midwife will be given to the family alongside the Maternity Neonatal Independent Senior Advocate (MNISA) details as per the MNISA process.

Relatives may wish to access the Hospital Chaplaincy Services and this request should be facilitated at the first available opportunity. They may require assistance in arranging contact with their own faith leader.

The family must be made aware that a referral to MNSI will be made as per Trust policy and consent gained for this. The family will be offered support throughout the investigation process.

Staff
The staff involved may require support from their immediate line manager, Professional Midwifery advocate, Occupational Health or GP. They may wish to access counselling services which the Trust will facilitate. If a trainee or locally employed doctor is involved in the incident the educational supervisor/college tutor will offer support and ongoing pastoral care if necessary. The educational supervisor will complete an exception report within 14 days and send it to Medical Education department.

A debrief will be arranged by the Clinical Matrons for all staff involved as soon as appropriate after the event and then again once all the facts are gathered. Debriefs will be repeated as required.

Ongoing support will be provided by the Associate Director of Midwifery/Deputy Associate Director of Midwifery, Obstetric Clinical Lead, Clinical Director, Managers, Pastoral team, and Professional Midwifery Advocates as required/requested.

8.0 Associated documents and references

BHNFT Clinical guideline for the Management of Stillbirth, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 24+0 weeks gestation

BHNFT Clinical guideline for the Management of Late Miscarriage, Medical Termination of Pregnancy (MTOP) and Early Neonatal Death from 20+0 to 23+6 weeks gestation**.**

SI Policy: Patient safety incident response policy.pdf (trent.nhs.uk)
Last Offices Policy: https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TADDocs/Care%20of%20an%20adult%20patient%20following%20death.pdf

Duty of Candour: https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TADDocs/Duty%20of%20Candour.pdf

9.0 Training and resources

Training will be delivered as outlined in the Maternity Training Needs Analysis. This is updated on an annual basis.

10.0 Monitoring and audit

Any adverse incidents relating to the 'Guideline for Maternal Death' will be monitored via the incident reporting system.

11.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when

necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

11.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1 Glossary of terms

List all terms/acronyms used within the document and provide a summary of what they mean.

Appendix 2 (must always be the last appendix)

Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author
3	15/08/2023	Update to post mortem section re: national recommendation for all post mortem examinations and update to maternity governance section regarding the joint review.	J Carritt, Governance Midwife
4	18/08/2023	Reviewed	
5	28/06/2024	Reviewed	

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Reviewed by Maternity Guideline Group	N/A
Reviewed at Women's Business and Governance meeting	17/05/2024
Approved by CBU 3 Business and Governance meeting	28/06/2024
Approved at Trust Clinical Guidelines Group	N/A
Approved at Medicines Management Committee (if document relates to medicines)	N/A

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Clinical Guideline
Document title	Guideline for the management of a maternal death
Document author (Job title and team)	Associate Director of Midwifery/, Governance Midwife
New or reviewed document	Reviewed
List staff groups/departments consulted with during document development	Midwifery Obstetrics Medical Examiner's Office
Approval recommended by (meeting and dates):	CBU 3 Business and Governance Meeting Date: 28/06/2024
Date of next review (maximum 3 years)	17/05/2027
Key words for search criteria on intranet (max 10 words)	Maternal death
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the FINAL version of this document	**Name: Natasha Geldart** **Designation: Quality, Safety and Governance Manager**

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): **Date approved:** **Date Clinical Governance Administrator informed of approval:** **Date uploaded to Trust Approved Documents page:**