University Hospitals Sussex
NHS Foundation Trust

Maternal Death

Maternity Protocol: MP076

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Cross reference:	**MP055** Perinatal Collapse in Pregnancy &Puerperium **CO18** The Verification, Certification And Notification of Death And associated Guidelines

Contents

Key Principles

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be used in the application of a protocol.

Scope

This protocol applies to:

- People who die during the childbearing period

Responsibilities

- Midwives & Obstetricians:
- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol
- Management:
- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff

Checklist for Maternal Death

Date: ……. Addressograph label Or

Name:……..

Address: ……..

DOB: ……. Trust number: …….

Notify Immediately:

	Name	Date	Signed
Next of Kin			
Consultant Obstetrician on call			
Maternity manager on call , who will contact:			
Head of Midwifery for the site;			
Clinical Director of Women's			
Chief Of Women's & Children's Service			
Director of Midwifery			
Divisional Director or the Director on call out of Hours. Via switchboard			
Clinical Site Manager (bleep)			
West Sussex Coroners Office 01273 404013 out of hours 101 covers Haywards Heath, Burgess Hill and East Grinstead Brighton and Hove Coroner's Office 01273 292046 out of hours 101			

Notify in Office Hours:

	Date	Printed & Signed
Named & Lead Obstetrician (site specific)		
Governance team		
HSIB		
DDO		
Chief nurse		
Named Community Midwife		
Bereavement midwife		
G.P. – name:		
Medical Examiner/Medical Examiner Officer		

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All health professional involved in all aspects of care aim to inform in person

Other Health Professionals that may need contacting

	Date	Print & Signed
Consultant Anaesthetist (if relevant)		
Health Visitor – name:		
Special Care Baby Unit/TMBU (if appropriate) x64377 RSCH X68489 PRH		
Director of Public Health Tel 01273 296580 (B&H) Director of Public Health Tel 01273 485300 (East Sussex)		
CCG Patient Safety team & there contact is BHCCG.SISussex@nhs.net		

Others

	Date	Signed
Press Office x 63417 out of hours 01903285285		
Bereavement Office RSCH x64611 Bereavement Office PRH x 68101		
Local Maternity & Neonatal System Email - wsxccg.lms@nhs.net		
The Maternity Office/Ante-natal clinic to ensure all further appts are cancelled and death is on PAS		
Any other professional who may have been		

involved e.g. social worker, CPN, substance misuse service, OASIS etc. Please list all those informed:		
Minister of Religion contact switchboard for relevant faith		
Occupational Health		
Staff support		

Ensure there is a follow up appointment with the family arranged with the Obstetric Consultant and HoM.

Date and Signed		

Name of person finally completing this form……..

1 copy of this form to go to governance team

1 copy of this form to go to HOM

1.2 Introduction

The purpose of this guideline is to assist professionals working in both primary and secondary care in effectively managing the rare event of a maternal death. There are specific actions required in maternity services detailed below, however recognising that this is not a common occurrence, this is alongside trust process, and details available support

Data on maternal deaths is collected by MBRRACE-UK (Mother and Babies: Reducing Risk through Audit across the UK). The MBRRACE-UK system is a secure web based electronic data collection system accessed by registered users only. A maternal death is defined internationally as a death of a pregnant person 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.

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 on the basis of cause into:

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

Healthcare Safety Investigation Branch (HSIB) (DOH 2017) part of the National Maternity Safety Strategy – Safer Maternity Care from March 2017, will investigate direct and indirect maternal deaths in the perinatal period. HSIB key message is that investigations will focus on learning and not attributing blame, and involvement of the family is a key.

1.2.1 Definition of a maternal death

A maternal death may occur in both clinical and non-clinical settings, either in the hospital or the community within 12 months of Birth.
It may include women who die following:

- following a miscarriage or termination of pregnancy
- as a result of suicide
- from cardiac disease or any other medical disorder
- due to an ectopic pregnancy
- following a surgical procedure
- following road traffic accident

It also includes pregnant people who die in critical care from conditions such as ARDS, or HELLP that developed as a result of the pre-disposing cause.

1.2.2 **Responsibility for reporting a maternal death**

Responsibility for notifying the Risk manager /MBRRACE coordinator that a maternal death has occurred should rest with :

- Consultant obstetrician on call /,
- Labour ward coordinator Midwife/midwifery manager on call
- General Practitioner who had overall responsibility for the pregnancy
- Consultant or general practitioner treating the woman throughout her final illness (**if the death occurred within one year following the end of her pregnancy**).

1.2.3 Immediate management of a maternal death within the unit:

- 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
- Determine whether the service is able to provide safe care to women in the immediate period and implement escalation policy. The on call maternity manager should be called in to assist.
- Consider calling a second obstetric team including a consultant (who may not be officially on call) who can take over on call clinical duties
- Confirm next of kin contact details and inform them if not present.
- **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 will delegate coordination responsibilities.
- Inform the named or on-call consultant obstetrician who will liaise directly with the coroner and communicate any immediate actions required on behalf of the coroner. The coroner should be notified if:

- The cause of death is unknown or suspicious
- The death occurs during an operation or before recovery from the effects of anaesthetic

1.2.4 **The following actions need to be taken:**

- An experienced member of staff is nominated to act as supporter to the birthing persons family and also to act as their main point of contact to prevent conflicting information being given.
- Determine whether next of kin wish religious or spiritual support to be offered via the hospital chaplain.

- The on-call consultant should meet the relatives as soon as possible. If the woman has a different named consultant, he or she should be informed when next on duty.
- The case notes and all documentation should be completed on BadgerNet, printed and photocopied and secured at the earliest opportunity. It should be noted that the Coroner may decide to hold a hearing on the case. In this instance any case notes and documentation will be sent to the Coroner's office.
- The consultant present/ on call may inform the on-call pathologist.
- The mortuary department should be informed that a maternal death has occurred.
- The serious incident requiring investigation (SIRI) policy should be activated and an internal investigation initiated, if appropriate. HSIB should be informed.
- The maternity manager on call will notify the HOM and DOM

Staff should be reminded not to discuss the case with anyone outside the clinical team. If they are approached by the media then advice should be to contact the Trust's lead for media. Under no circumstances should staff intentionally or inadvertently comment about the case on social media.

1.2.4 If a perimortem caesarean section has been undertaken the responsibility for the baby should be by the named married parent or civil partner. For relationships that are unmarried or a non-civil partnership or surrogacy parental responsibility has to be applied for and granted through the family courts. The safeguarding team can support with ongoing management.

1.2.5 **In the event of the baby dying in the uterus, the following should be taken into consideration:**

- If the baby is in utero the baby will be removed by the pathologist at the post mortem examination. The definition of a stillbirth does not include the removal of a dead baby from its dead mother at post-mortem for the purpose of ascertaining the cause of death because the post-mortem is being carried out on the mother rather than the baby. Registration of a baby in these Circumstances, over 24 week's gestation as a death is not legally required. This advice has been given by the Registrar General (Office for National Statistics). However, consideration must be shown to the wishes of the family. A medical practitioner may issue a death certificate for the dead baby, which will enable the family to register the baby as stillborn. Most Registrars of births, deaths and marriages will comply.

- Local stillbirth/neonatal death procedure should be followed, whether the baby is to be registered as a death or not and the death reported to MBRRACE.

1.2.4 **Who should be informed in the event of a maternal death?**

- Next of kin: office to be notified of death as per hospital policy. The attending doctor must promptly and accurately complete a death certificate. It is appropriate for the relatives to deliver the certificate to the Registrar of births, deaths and marriages.
- The Coroner's officer may insist on being present when the relatives visit the body (bodies) in the mortuary. Sensitive handling and coordination will be required if this situation occurs.
- Out of hours, the hospital administrator on-call should be notified. During office hours the risk office is notified.
- The consultant or GP responsible for the case must inform the MBRRACE co-ordinator that a maternal death has occurred. This can be done during office hours.
- Doctors in other specialities or GPs may be less aware of the need to report maternal deaths than maternity staff. Any member of staff who becomes aware of a maternal death can inform the Risk manager/ MBRRACE coordinator who can then seek further details from the relevant doctor.
- Once notified, the MBRRACE co-ordinator will liaise with the consultant and request any further information which may be required for the official report.
- If the death of the baby has also occurred, the local MBRRACE coordinator must be notified.
- The deceased's named midwife must be informed in person, do not leave a message. The named midwife should be updated regularly.
- The deceased's GP and health visitor must be informed as soon as possible on the next working day.
- If the deceased has been admitted to RSCH /PRH having been treated or booked in another area, the senior midwife and consultant at that hospital must be informed.
- If the person who died was not resident in the hospital's local district, the local MBRRACE coordinator will ensure that the MBRRACE co-ordinator in the area of residence is notified.
- Children's Services: if the baby is alive parental responsibility does not automatically pass to the second parent if they are unmarried. The named midwife for Safeguarding should be notified; and, if appropriate, Children's Services informed.
- If the death has occurred outside the maternity department, the (DOM/HoM), the named obstetric consultant, GP or midwife involved in the pregnancy care should be informed

Relatives may wish their local minister of religion to be notified. They may also wish for this person to be with them at the hospital. If they are uncertain or would like someone of faith to be with them, the hospital chaplain should be contacted.

1.2.5 Managing a maternal death in primary care:

- The deceased's GP will be responsible for ensuring that the MBRRACE co-ordinator has been notified.

- The GP should also notify the hospital on the next working day if the birthing person had given birth or received care there.
- Each general practice should ensure that all staff in the primary care team have access to and understand the procedure to be followed if a maternal death occurs.

1.2.6 Reporting the maternal death to MBRRACE-UK:

Maternal deaths should be notified by ringing the MBRRACE-UK office on 01865 289715.

The Risk manager/ MBRRACE coordinator needs to have the woman's information to hand and the following available:

- Postcode and address
- Date of Birth
- Date of death
- Suspected cause of death
- Place of death
- GP name and contact details including postcode and telephone number
- Booking hospital
- EDD
- Date of delivery
- Place of delivery
- Pregnancy outcome
- Obstetric consultant
- Short clinical details of case

2. Paperwork and Documentation

2.1 Find any maternity paper notes and print from BadgerNet all antenatal, labour and postnatal documentation.

2.2 Photocopy or print additional notes for –
1 set to Bereavement Office
1 set to governance team

2.3 Complete Datix form and obtain statements from those involved.

2.4 Ensure that computer entries are completed.

2.5 Ensure that any future appointments e.g. ANC, physio, scans, parent education are cancelled by clerks.

2.6 Check involvement in any clinical trials to avoid follow up e.g. See notes at end

2.7 Referral to Medical Examiner and Coroner

2.8 Maternal death certificate – is issued by the Coroner following PM if no inquest is held, not by hospital staff. Registration is done by the Coroner if an inquest is held.

3. Property

3.1 Property book is kept on main desk by the ward clerks if none available contact the CSM to assist

3.2 List property in book and give a copy of this to the relatives.

3.3 If jewellery left in situ, record in notes.

4. Body

4.1 Check religious/ cultural considerations before performing care after death

4.2 Last Offices pack (now called care after death) available from the bereavement office or via the clinical site manager

4.3 2 name bands - 1 wrist, 1 ankle, and card to be attached.

4.4 Consider taking foot and handprints and a lock of hair (as with babies) and use a memento folder.

4.5 Send the labelled placenta in a container fresh with the body. The placenta should only be placed in formalin if there is any delay in transfer to the mortuary or post mortem.

4.6 Removal of body via main porters to mortuary x64210 RSCH and x64287 Bleep via switchboard

4.7 Inform relatives that they can view in Chapel of Rest.
If during office hours, arrange in advance via mortuary x64144 RSCH and x64449 PRH Out of hours, can be arranged via Main Porters.

5. Information to be given to relatives (all this information is in a folder in the Labour Wards lead office)

- Counselling service information.

- Contact no. of hospital chaplain bleep duty chaplain via switchboard
- Bereavement Office RSCH x 64611
- Bereavement Office PRH x 68101
- Named midwife/ DNM/consultant for future contact
- Details of future appointments
- Leaflet 'guidance following a bereavement' & letter from bereavement office with contact telephone number. You will need to explain that this is general information following a death and does not mention very much about the coroner.
- Information on 'What to do after someone dies' written by the UK government. www.gov.uk/when-someone-dies

6. Following a Maternal Death

6.1 Hot Debriefing for all staff including midwives, doctors, student midwives, ancillary staff, bank staff, ODPs, theatre staff, Special Care and TMBU staff, medical students etc or hospital chaplain. Names of all staff involved/affected should be taken for further support. The midwifery manager can coordinate this, the debrief should be facilitated by the most suitably trained individual (trim trainer, PMA, manager on call)

6.2 Some allied services may not be present for this, so staff should ensure all names and contacts are documented so there can be an offer of support, for example , SECamb, unintended witnesses

6.3 The governance team and midwifery managers will ensure appropriate support for all staff and associated involved contacts this will include setting up and communicating details of an AAR or signposting to appropriate support including PMA, line manager , occupational health, VIVUP

6.4 Restock all emergency equipment used, drugs, and CAB boxes

6.3 **See example letter at the end.**

7. Notes

7.1 Registration

Baby - If the baby survives, the partner can only register in their name if they were married. If not married but the partner was present at the delivery/will be responsible for the child, they can register the birth but will NOT have their details included on the birth certificate. They are required to apply for a parental responsibility order under the Children Act Section 4 via a solicitor. They would then be named as the parent on the birth certificate. (Some unmarried couples already have a parental responsibility agreement in place). They could also apply for a declaration of parentage under Section 56(1) of the Family Law Act 1986 as amended by Section 22 of Family Law Reform Act 1987 also through a solicitor.

Birthing person – if the Coroner requests a PM but does NOT hold an inquest, the Coroner will issue the death certificate directly to the Register Office and a relative must register the death in person within 5 days. Ideally the relatives should take the following:

- Medical card
- Birth and Marriage certificate.

7.2 If an inquest is held, then the Coroner notifies and registers the death and no informant is required to do anything.

7.3 It is useful to explain to inform the relatives to ask for several copies of the death certificate at that time of registering the death for insurance, wills, etc, but they will need to pay for these.

8. Funeral

8.1 Consider sending a representative from the maternity unit e.g. named midwife if appropriate with another person for support.

8.2 **Coroner**

8.2.1 Will be involved if death is a direct obstetric cause, during an operation, before recovery from an anaesthetic, is sudden and unexpected or is an unknown cause or within a year of delivery.

8.2.2 Will decide if a Post Mortem examination is required. The results of which are available from the Coroner's Officer.

8.2.3 Relatives consent is not needed but they will be informed by the Coroner's Office about where and when the examination is going to take place, and can be represented at the examination by a doctor. The Coroner will then issue the forms for registration, and cremation if necessary.

8.4 Inquest

8.4.1 An Enquiry into the medical cause and circumstances of the death. Called by Coroner, held in a public court and relatives can attend.

8.4.2 The funeral can take place before the Inquest.

8.4.3 Medico-legal will assist the Coroner in gathering evidence. Any key staff members should contact medico-legal to provide assistance

Date

Private and Confidential

Dear xxxx

RE: After Action Review (ARR) Meeting on ??/??/????

We are reaching out to you following an emotive and highly challenging incident that happened on (date of event + a brief summary of event).

The (who called the AAR i.e. maternity leads) would like to invite you to an After Action Review (AAR). *An AAR is a discussion of an event that enables the individuals involved to learn for themselves what happened, why it happened, what went well, what needs improvement and the lessons learnt.*

No minutes will taken

The AAR is planned for (date) at the (where) at (time). (The names of the people facilitating the session) will be facilitating the session. The focus is on staff wellbeing and recognition of the impact that our clinical work can have on our emotional state. It is separate to the structures of management.

I hope as many as possible can attend but understand this is not always possible. Please look at the recipients of this email and consider if anyone else should be included.

Please RSVP.

Kind regards,

XXXX XXXX & XXXX XXXX
(AAR Facilitators)

10. **Procedure for doctors certifying deaths at UHS East**

- The Bereavement Office staffs are in close contact with the Coroner's Officers and work the same hours of 0800 – 1600 hrs Monday to Fridays (excluding Bank Holidays).

- Most people are cremated rather than buried after they die, which is why doctors in EVERY CASE must complete Cremation form 4 at the same time as the Medical Certificate of Cause of Death (MCCD). This will save you being called back again, and avoid undue delay and distress for bereaved relatives.

Certifying a Death

Certifying a Death and completing the necessary documentation to allow families to arrange a funeral and cremation are part of the responsibilities of the medical profession towards patients. Undue delay in the process is distressing for families at a time when they are already trying to come to terms with their loss. It is imperative therefore that we have a clear understanding of who is responsible for which parts of the process, so as to minimise this distress. In hours, all deaths must be discussed with the Medical Examiner (ME), who will then advise on whether Coronial referral is necessary. Prior to discussion with the ME, the Medical Examiner Referral Form must be completed on Panda (this can be found under the tab 'Data Forms' on the patient's homepage). The Medical Examiner Officers (MEOs) will be happy to advise on any aspect of the process and help you with contact details of the duty ME. The MEOs can be contacted on x66287 (RSCH) and x68101 (PRH).

Who is responsible for certifying death?

Responsibility rests with the team caring for the patient at the time. Patients admitted by another team, who die before being 'handed back' to the usual team are still the responsibility of the admitting team. Patients who die out of hours are the responsibility of the team normally caring for them, but it is the responsibility of the doctor confirming death to hand this information on to the relevant team, to avoid undue delay.

When should certification take place?

Ideally the process of certification needs to be completed before the start of routine activities for the day, and it is the responsibility of the team to make sure this happens, irrespective of leave or other issues. More junior members of the team are not expected to complete the paperwork on their own until they have become

familiar with the process, just like any other practical skill. Senior members of the team should also be able to advise and the Medical Examiner Office will guide you through the process of either Coronial Referral or death certification as appropriate and again this must happen in a timely fashion.

What forms need to be completed?

If Coronial referral is not required or if the Coroner issues authorisation for the referring doctor to complete the Medical Certificate of the Cause of Death (MCCD), via the issue of a Form A100, both the death certification paperwork and cremation form must be completed for all patients. Although this means that some patients will have the cremation paperwork completed when this is not required, the proportion of patients who are cremated as opposed to buried is such that completing both forms on all patients is the most time effective approach overall, and the one least likely to result in delays for patients.

The Medical Examiner or Coroner's Officer may need further information. As a result, clear and full contact details need to be left on the Panda Referral Form, particularly if the doctor is about to be off for a few days (nights, leave etc).This also applies to doctors who certify death out of hours, but then are away, when the day team hasn't known the patient. It is mandatory to also complete the details of the Consultant responsible for the case.

Procedure

1. Deaths under 18 years of age:

1.1 All deaths must be reported to the Coroner . You are not able to complete the MCCD, even if the death is expected and/or the cause known without Coronail referral.

1.2 If, after authorisation from the Coroner, the doctor can then complete the MCCD, they must attend the Bereavement Office to do this. The Bereavement Office is on Level 5 of the Millennium Building. Please also complete the Cremation form at the same time.

2. Deaths at or over 18 years of age

2.1 All deaths must be reported to the Medical Examiner (Mon – Fri 0800 – 1600hrs) via the Medical Examiner Office as soon as possible by one of the doctors.The ME will advise on the need for referral to the Coroner. In

2.2 If the ME or the Coroner's Officer gives permission for the MCCD to be completed, then the doctor must attend the Bereavement Office to do so. The Bereavement Office is on Level 5 of the Millennium Building. Please also complete the Cremation form at the same time.

4. Deaths of patients who for cultural reasons need to be buried as soon as possible:

If such a death needs to be reported to the coroner, there is a coroner's officer who is available 24 hours a day. They are contactable via the Police non-emergency phone line by dialing 101.
If the MCCD can be completed then the doctor must do so as soon as possible by contacting the duty site manager.
The Registry Office of Births, Deaths and Marriages must be contacted in order for them to register the death and prepare the release papers.
A copy of the death certificate must be put into the patient's notes as the Bereavement Office will need to notify the GP the next working day.
The doctor must print their name on the MCCD, or the Registry Office will NOT process it for the family and the funeral will not take place.

5. Reasons a Doctor needs to refer a death to the Coroner

- Death may have been caused or contributed to by poisoning whether intentional or accidental including poisoning by an otherwise benign substance.
- Exposure to or contact with a toxic substance.
- The use of a medicinal product controlled drug or psychoactive substance.
- Death may have been caused or contributed to by violence.
- Death may have been caused or contributed to by trauma whenever it occurred (e.g. a fall at home or a road traffic collision) however minor.
- Death may have been caused or contributed to by the deceased's own actions e.g by drug use self-harm or self-neglect.
- Death may have been caused or contributed to by neglect from others (including lack of treatment).
- Death may have been caused or contributed to by a medical procedure treatment or during recovery whether invasive or not.
- Death may have been caused or contributed to by the deceased's employment or former employment.
- The cause of death is unknown.
- Death occurred whilst in custody police prison or compulsary detention under section of the Mental Health Act (DOLS are not automatically reportable but consider vulnerability).
- Death occurred shortly after police contact or may have been caused or contributed to by police action or inaction.
- The medical practitioner reasonably believes that there is no attending medical practitioner available to sign a certificate of cause of death in relation to the deceased.
- The medical practitioner is not available within a reasonable time of the

death to sign a certificate of cause of death.

- The identity of the deceased is unknown despite reasonable steps having been taken to identify them.
- The deceased is under the age of 18 years.
- There are any other features of the death which concern you including any general anxieties (please say what they are).

If you are in any doubt as to whether a death should be reported, contact the Medical Examiner Office in working hours or the Coroner's Office out of hours for further advice. The Coroner's Officer is contactable out of hours via the Police non-emergency phone line by dialing 101.

References:

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2. Mothers & Babies Reducing Risk through Audit and Confidential Enquiry across the UK (MBRRACE-UK). (2017). *Saving Mothers Lives:Improving Mothers' Care.* Lessons learned to inform maternity care from theUK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15
    a. www.npeu.ox.ac.uk

3. MBRRACE-UK 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 (2021)

4. National Confidential Enquiry into Patient Outcome and Death. (2001)
    a. *Changing the Way We Operate:The 2001 Report of the National*
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5. Start RD et al. Clinicians and the coronial system: ability of clinicians to recognise reportable deaths. Br Med J 1993; 306: 1038-41.

6. Registration of Deaths www.gov.uk
        i. What to do when someone dies: step by step
        ii. Register a death

7. 7. Guidance-for-Staff-Responsible-for-Care-after-Death.pdf (england.nhs.uk)