University Hospitals Sussex
NHS Foundation Trust

Maternal or Birthing Parent Death

Contents

Maternal or Birthing Parent Death

1.0 Introduction

The purpose is to provide operational guidance for all healthcare professionals supporting partners, families and staff following a maternal or birthing parent death.

This is for deaths during and up to 1 year after the end of the pregnancy, whether the death is anticipated or unanticipated, and regardless of where the death occurs.

It outlines the practical procedures that need to be followed, who should be contacted, who requires support and how this can be managed across the various settings in which a maternal death might occur.

The intention is to make the process as compassionate and straightforward as possible for families and staff.

2.0 Abbreviation used within this clinical document

DoM Director of Midwifery	**HoM** Head of Midwifery
ICU/CCU Intensive Care Unit / Critical Care Unit	**ICU/CCU** Intensive Care Unit / Critical Care Unit
MBRRACE-UK Mothers and Babies: Reducing Risks through Audit and Confidential Enquiries	**MCCD** medical certificate of the cause of death
MNSI Maternity and Newborn Safety Investigations	**PSIRF** Patient Safety Incident Response Framework

3.0 Immediate actions following an unanticipated death

In the event of an unanticipated maternal death, the following should be informed as soon as possible:

- **Obstetric Consultant-on-Call**
- **Anaesthetic Consultant-on-Call**
- **Head of Midwifery** (or deputy)
- **Director of Midwifery**
- **Senior / Midwifery Manager on-Call**
- And a representative of the **senior management** for the hospital.
- **Patient Safety Team**

Staff involved in the death should ensure they write up their notes before going off duty with clear, legible, factual details of their actions and events. The notes should also include what the partner/family members have been told, and what they understand of the events surrounding the death.

At this early stage, ahead of postmortem findings and any review or investigation, only factual information about the circumstances of the death should be discussed and recorded in the notes. Speculation as to the cause of death should be avoided.

It is important to make it clear that the cause of death is not yet known and cannot be confirmed until the postmortem results are available.

This is to avoid apparently conflicting information being given at different stages, which can cause distress to the family.

The senior clinicians (consultants on call for obstetrics and anaesthetics) and Head of Midwifery should attend and meet with the staff involved to ensure they are fully briefed regarding the circumstances surrounding the death.

They should then meet with the next of kin to start the process of discussions with them, and to understand their perspectives of the care received by the woman or birthing person, as well as deal with any questions they have where this is possible with the information available at this stage. Bereavement support for the partner and family should be initiated as soon as possible.

At this point it is important to verify which member(s) of the family have been identified as next of kin on BadgerNet Maternity and, thus, have a right to be kept informed; this is not always straightforward, especially if the woman or birthing person and their partner were not married or in a civil partnership. Please see Code A - Guiding principles and the fundamental principle of consent.pdf (hta.gov.uk) for further guidance.

The Lead Medical Examiner and the Senior Coroner have confirmed that all tubes and lines can be removed from the deceased, even if there is the need for a postmortem examination. The only exception to this is where there is a concern that they may be implicated in the cause of death. The anaesthetic team involved in the case is responsible for making the decision to remove any tubes or lines.

The **Site Manager** will be able to give advice regarding preparing the body and might help coordinate communication with the mortuary staff. (Where the death is unanticipated, consideration should be given to forensically preserving materials connected with the care of the woman or birthing person, including but not limited to drug ampules, syringes, monitors, etc.)

The need to refer the case to the coroner or procurator fiscal (in Scotland), and for a local review and possible investigation should be conveyed to the partner/family.

As part of the Statutory Duty of Candour the family should be informed that the Maternity and Newborn Safety Investigations (MNSI) programme will, with their consent, be conducting an investigation of all maternal deaths up to 42 days after the end of the pregnancy except where the death was by suicide.

The following individuals should be notified by the **midwifery coordinator** immediately, within 2–3 hours after the death, regardless of when the death occurred:

- Relatives/next of kin.
- Consultant Neonatologist-on-Call (if the baby has been born and transferred to the neonatal unit).

- Director of Midwifery to be informed.
- Patient Safety Team.
- Clinical Director (or deputy).
- Board member or senior member of the hospital management team.
- Site Nurse Practitioner
- Mortuary Technician via switchboard.

The following individuals should be notified by the **midwifery coordinator** immediately, within 2–3 hours after the death, regardless of when the death occurred and attend the unit if not already present:

- Consultant Obstetrician-on-Call.
- Consultant Anaesthetist-on-Call.
- Head of Midwifery (or deputy) or senior nurse in charge of the non-maternity setting.

4.0 Actions within 24 hours

Two individuals (obstetric and midwifery) should be nominated as named contacts for the family going forward and their contact details should be provided.

The role of the key contacts with the partner and family is to:

- Offer condolences.
- Be the regular point of contact and to provide continuity.
- Act as the main point of information to avoid conflicting information being given.
- Be available after the partner and family have left the hospital.
- Provide written information following any meetings.
- Be able to allow adequate time to talk to the partner and family which will require good listening skills.
- Absorb and listen to the partner's and family's questions and distress.
- Expect and allow expressions of anger and other emotions while not taking these personally.
- Facilitate practical arrangements, such as writing any letters which are required and organising free or reduced cost parking for visiting) ie outlining the need for additional time off work for relatives.
- Ask the partner and family if they would accept staff members attending the funeral.
- A letter written to the GP, community midwife and health visitor, copied to the partner and family which sets out who is their point of contact, what will happen next, and arrangements for the care of the baby will help to ensure a coordinated and well communicated approach to the immediate and longer-term support.

The consultant obstetrician should discuss all maternal or birthing parent deaths with the coroner within the first 24 hours of the death. If the death has been anticipated for some time a postmortem may not be required.

If a coroner-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.

Service user/patient documentation should be downloaded/scanned and stored securely in the Patient Safety digital folders. It should be made available to the investigating team, those writing accounts of events, the coroner, MBRRACE-UK and the family on request. When families consent, for an MNSI referral, the investigators will also require a copy of the notes.

The following individuals should be notified within 24 hours of the death or the next working day:

- Woman or birthing person's GP.
- Woman or birthing person's named midwife/team/booking unit.
- Woman or birthing's named health visitor/team if appropriate.
- Hospital bereavement services.
- Other specialist medical staff involved in the woman or birthing person's care, e.g. cardiac services.
- Trust/health board risk manager, who will inform commissioners and any other bodies to which the trust or health board is accountable.
- Maternity unit risk manager who will liaise with MNSI.
- Director of nursing.
- Coroner.
- Social services (if appropriate).
- Trust/health board communications officer.
- Head of litigation and complaints.

5.0 Actions within the first week

An experienced senior member of obstetric or midwifery staff *not* involved in the care of the woman or birthing person should be nominated to coordinate a case review as early as possible.

All deaths during pregnancy and up to 1 year following the end of the pregnancy, regardless of how the pregnancy ended and the cause of death, should be reported to the national Confidential Enquiry into Maternal Deaths (MBRRACE-UK) within 7 days.

Verbal and written Statutory Duty of Candour must be completed as per Trust DOC policy and CQC regulation 20. Duty of Candour Regulation 20

6.0 Actions required when the death occurs outside the maternity or gynaecology department

When a maternal or birthing parent death occurs in early pregnancy, or a pregnant woman or birthing person 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 and gynaecology staff to ensure the correct processes in relation to a maternal death are followed; this can be facilitated by contact with the **Head of Midwifery** or the **Director of Midwifery**.

Many women or birthing people who die do so following a period in ICU/CCU. If the death occurs shortly after admission without the prior involvement of maternity staff, then the Head of Midwifery should be contacted.

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 or birthing person'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.

7.0 Actions required following anticipated deaths

In women and birthing people with significant pre-existing morbidity where death is a possibility, a plan should be put in place with regard to who should be informed in the event the woman or birthing person 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.

When the woman or birthing person has been unwell for some time prior to their death, or death is anticipated because of underlying ill health, consideration about legal guardianship for the baby should be discussed and formally agreed while the woman or birthing person can still be involved in the decision making.

Anticipated deaths can still be traumatic for staff and will require the same level of documentation and staff support as for unanticipated deaths.

Where a coronial/procurator fiscal postmortem is not required the option of a hospital postmortem should be discussed and offered to the next of kin.

It is best practice to review the whole pathway of the woman or birthing person's care to consider if there were any patient safety issues, and other aspects of care earlier in the woman's journey, which affected the quality of their care and the outcome, and to improve care for future women and birthing people with the same condition.

8.0 Postmortem and death certification

Following discussion with the coroner, it may be agreed that the coroner need not be involved and a medical certificate of the cause of death (MCCD) can be issued by the qualified attending medical doctor. In the event that a medicolegal postmortem is not required, a sensitive discussion with the family will be needed to seek consent for a postmortem, as this may add to the evidence about the cause and circumstances of the death, identify hereditary factors, which may have implications for other family members, or to advance medical research.

A death certificate cannot be issued if a coroner postmortem is going to be carried out. In this event, the death certificate will be issued by the coroner/procurator fiscal once the pathologist has reported.

If an inquest is going to be held, there will be a longer delay.

9.0 Ockenden requirements following maternal or birthing parent death

LEARNING FROM MATERNAL DEATHS	
Essential action Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings	• NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death. • This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required. • Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning

Ockenden Report Final 2022

External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. Ockenden Report Final 2022

10.0 Registering death

The **family** need to register the death with the local register office who will issue the death certificate. The funeral can be held once a death certificate has been issued.

If there is going to be delay, either owing to complexity of pathological analysis and/or an inquest, the coroner can issue a certificate granting release of the body without the cause of death to allow the funeral to proceed.

Once the coroner is involved the family should be put in touch with their office, and all advice concerning death certification, release of the body and timing of the funeral (cremation or repatriation) will be provided via this route. The hospital bereavement office and patient services should be able to provide written information.

Staff should be sensitive to the faith needs of the family. Where a requirement to urgently release the body for immediate burial (e.g. for religious reasons) cannot be met this should be sensitively explained.

11.0 Baby born alive

In many cases of maternal or birthing parent death there will be a surviving baby. The baby might be admitted to the neonatal unit because they require clinical care or simply as a place of refuge in the circumstances. If the baby has been admitted to the neonatal unit, the neonatal team must be made aware of the maternal or birthing parent death as a matter of urgency.

It is important for the **neonatal team** to establish who has legal parental responsibility for the baby, particularly if the parents were not married or in a civil partnership.

The **safeguarding team** should be involved in these discussions.

Once parental responsibility has been established every effort must be made to involve the father or person with parental responsibility, and family, in the baby's care, progress and decision making.

It is important to involve the community team (**GP, midwife, health visitor** and relevant **social agencies**) in the plans to support the person with parental responsibilities and those caring for the baby and any siblings, especially in those circumstances where there is little family support.

12.0 Stillbirth / neonatal death

In the event that the baby was born (including by perimortem or postmortem caesarean birth) and did not survive, consideration needs to be given to managing the perinatal bereavement alongside the maternal bereavement.

The involvement of the **Perinatal Bereavement Midwife** will ensure that the baby's body is cared for appropriately (for example with the provision of a *cold cot*), the partner and family are involved if they wish to be and activities such as *spending time with the baby*, taking *photographs* and *memory-box* making are not forgotten.

The bereavement checklist should be completed to ensure that all relevant professionals are informed about the baby as well as maternal death. Providing information about the local support groups, for example, the stillbirth and neonatal death charity Sands may prove helpful for families later.

The practicalities of registering the stillbirth/neonatal death and maternal death will also need to be discussed with the partner and family, along with information about arranging a funeral. The bereavement midwife will be able to provide information and support as these decisions are made.

If still in utero, they do not have to be buried separately. Some families decide that they want to honour their baby's memory by arranging a separate burial or cremation.

All eligible neonatal deaths and stillbirths will be notified to MBRRACE and taken through the Perinatal Mortality Review Tool process. Refer to PMRT SOP for further information.

13.0 Family support and bereavement care

There is some evidence which suggests that the presence of family members at the resuscitation, while stressful for staff, may help family members accept the reality of the death.

The family will need access to nonclinical emotional and psychological support and, in many instances, the chaplaincy unit in the hospital can help with this in the first instance or provide advice.

Enable the family members, if they wish, to see and spend time with the woman prior to transfer to the mortuary. Information should also be provided as to how family members can see the woman or

birthing person once they has been transferred to the mortuary. Each trust or health board should have a local guideline covering this which applies to the hospital in general.

Private space should be found for the family away from the main birth unit, such as in the bereavement suite. This should allow for access to toilets and shower facilities where possible and access to food and drinks. It should be away from the sounds of other women and families where possible. Be sensitive that contact with other new parents or their visitors may be distressing, for example, at a vending machine, on a neonatal unit or in a waiting room.

As part of the on-going discussions with the partner/family, it will be important to ascertain to what extent they wish to be involved/ informed about the review/investigation as it progresses.

It is also important to ensure that they are able to ask any questions they may have about what happened and why. Plans as to who and how to communicate the results of a hospital postmortem to the partner/family should be made ahead of the findings being available; the communication of findings from coroner postmortem are the responsibility of the coroner.

14.0 Organ donation

During the course of these early discussions, the partner and family may raise the possibility of organ donation. If the woman or birthing person died on the ICU/CCU, staff will be familiar with the procedures and able to deal with this request and, where appropriate, may themselves raise this possibility with the partner and family.

If the woman or birthing person died elsewhere, advice from **ICU/CCU staff** would be helpful. Specialist nurses for organ donation (SNOD) should also be involved if donation is being considered. If the death is likely to be dealt with by the coroner and may not grant permission.

15.0 Follow-up support for the partner and family

The nominated key contacts should stay in touch with the partner and family to keep them informed about the progress of the case review and any investigation. In cases of unanticipated death, the probable cause of death is often altered by the findings of the postmortem which may not be available for some months. While it is very important that the partner and family are not given conflicting information, ‘Duty of Candour’ in England and Scotland is a legal duty for hospitals to inform and apologise to patients and their families if there have been mistakes in their care that have led to significant harm.

Communication with the partner and family in an open and transparent way regarding the care and treatment provided is the appropriate action in every setting. However, care should be taken to ensure that they do not receive conjecture or assumptions about the cause of death until evidence is established.

Following discussions and meetings with the partner and family members, it is important to keep records of all conversations and what the partner and family have been told regarding the circumstances surrounding the death and eventually the cause of death. It is best practice to follow up every meeting with a letter to the partner and family members copied to the GP.

16.0 Staff support

Consider the shift being completed by other medical and midwifery staff; the unit should call on its escalation policy to keep the unit safe for other women and birthing people and to ensure that staff are provided with appropriate support.

An immediate team checkout (hot debrief) should be performed including the support and clerical staff, the porters and the laboratory technicians. One of the purposes of such as debrief is to enable staff to freely speak about the level of distress they are feeling.

Staff should be reminded that the case should not be discussed with other parents or families or on social media.

The line manager of all staff directly involved should be informed of the event so individualised support can be given, including for senior as well as junior staff; consider appointing someone to stay in touch with staff members when they are off duty with a further clinical debrief arranged at a later date.

All staff should be reminded of how to access hospital counselling services. Line managers or HoMs can assist with access to support.

The Professional Midwifery Advocate (PMA) team should be informed of all staff that have been either directly or indirectly involved, to offer further and on-going individual support.

Consider moving the directly affected staff to less acute areas of work over the short or medium term and/or modifying working patterns if they wish. Support for staff before they return to work should also be offered. If this is not possible, offer support when they next come to work or work in that area.

Liaison between midwifery, nursing and medical student tutors and educational supervisors is important to ensure ongoing support.

The educational supervisors of all trainee doctors should also be informed of their involvement, however superficial. Most cases will need to be recorded on the ‘Enhanced Form R’ as part of the annual review of competence progression and appraisal process.

The confidence of all staff may be affected and therefore it should be ensured, where possible, that the consultant on call and Head of Midwifery is available rapidly at all times.

Staff may need additional support if there is media involvement (see below).

Staff may at a later stage be asked to provide written statements regarding their involvement in the care of the women and the events leading to the death, for example prior to an MNSI investigation and an inquest.

Advice should be provided as to how these statements should be drafted (e.g. stating only the facts, avoiding speculation, drawing on their contemporaneous notes). Support and review of the statements should be offered by a senior clinician not involved in the death prior to their statement being submitted.

17.0 Media involvement

Any media involvement should be channelled through the trust/health board communications team; the trust/health board should have a communications policy that should be followed in all circumstances to protect patient, partner and family confidentiality which is paramount. Only staff nominated by the trust/health board should speak to the media on behalf of the trust/health board.

If there is likely to be media involvement, all staff should be made aware of the possibility of covert media enquiries.

Staff involved in the death may need additional future support, particularly if the event is covered in the media sometime after the event, for example, if an inquest is held.

18.0 Reflections, feedback and shared learning

At an appropriate point after the death, invite all the staff across the unit, those involved across the hospital and any staff external to the hospital who were involved (for example, paramedics and ambulance staff) to a debrief and discussion of the case.

This will help disseminate the lessons to be learned, reduce potentially ill-informed discussions and ensure the staff believe they can rely on the local review and any investigation to be open, honest and useful.

19.0 Audit & monitoring

All maternal or birthing parent deaths are investigated locally via datix and the patient safety incident response framework (PSIRF), externally via MNSI if within set criteria, coroner and nationally via MBBRACE.

References

RCOG Managing Events Surrounding a Maternal Death and Supporting the Family and Staff; Good Practice Paper No. 18 February 2024

Ockenden Report Final 2022

https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

Appendix 1: Contacts and actions: IMMEDIATE

Contact	Name/ Number	Date	By whom?
Next of kin			
Consultant obstetrician on call (to attend hospital)			
Consultant Anaesthetist (to attend hospital)			
Head of Midwifery (or Deputy) (to attend hospital)			
Senior/Midwifery Manager on-Call (to attend hospital)			
Patient Safety Team			
Clinical Director (or deputy)			
Board Member			
Site Nurse Practitioner			
Mortuary (technician on call - if out of hours)			

Staff Nominated to act as relatives' main point of contact:

Name: ……

Name: ……

Maternal records:

- Ensure **ALL** records completed (try to write as complete an account as possible from as many people as possible).
- List ALL personnel present (and their job title).
- Crash call record to be kept.

☐ **Notes photocopied ASAP x2–3:**

- If for postmortem – copy to go with mother to mortuary/coroner
- Copy to go the MBRRACE-UK reporter
- Copy to go to MNSI if a relevant death and when consent has been obtained

Investigations (as discussed with consultant):

- ☐ Swabs
- ☐ Cultures
- ☐ Placenta: in situ / histology / with mother for postmortem
- ☐ Blood from central venous access for fetal squamous cells 'squames' (test for amniotic fluid embolism)
- ☐ Other ……..

Appendix 2: Contacts and Actions: WITHIN 24 HOURS (1 working day)

Contact	Name & contact number	Date notified	Print name
Woman or birthing person's Link Consultant (maternity)			
Director of Public Health			
Integrated Care Board Officer			
Woman or birthing person's GP -			
Woman or birthing person's named midwife			
Woman or birthing person's health visitor			
Trust/health board risk manager			
Maternity unit risk manager			
Director of Nursing			
Coroner	Contact by coroner's office		
Social services if appropriate			
Communications officer	Contact by trust risk manager		
Head of Litigations & Complaints	Contact by trust risk manager		

Coroner /postmortem/death certificate
Name of coroner informed/discussed case ……
Postmortem to be performed by: ☐ Coroner (or Procurator fiscal) ☐ Hospital
Death certification provided by: ☐ Coroner (or Procurator fiscal) ☐ Hospital

Other hospital doctors informed (e.g. SLE, diabetes, renal, cardiology)
By name ……..

☐ Maternity risk manager informed
☐ Received copy of notes
☐ Incident form completed and sent to risk manager

Baby care
If baby born dead – use baby checklists
If baby alive – name of next of kin: ……
Location of baby or fetus: ……
Registration required (please circle) Yes / No

☐ Relatives referred to hospital bereavement office
☐ Counselling offered (please circle) Accepted / Declined
☐ Meeting with consultant arranged
☐ Postmortem result discussed

Appendix 3: Template letter for communicating with GP

Dear [insert name]

It is with sadness that I write to tell you of the recent death in our unit of [*insert name*]. [*Insert name*] had been admitted on the [*insert date*] for birth/with symptoms of [*insert symptoms*] and was managed under the care of [*insert consultant name*]. [*insert name*] died on [*insert date*].

> *Provide a brief synopsis of the clinical problems and the actions taken, including any transfer of care to another unit such as CCU/* ICU or to another hospital.

I have met with the partner [*insert name and address*] **and/or** family [na*me and address and nature of relationship*] and explained the events that we believe led to their death.

i) We have reported the death to the coroner and have been able to issue a death certificate and this gives the cause of death as [*insert details*].

OR

ii) We have been unable to issue a death certificate at present until the cause of death is confirmed by postmortem, which is being done under the coroner's instruction.

iii) Give any information about organ donation, etc.

As [*insert name*] death was associated with pregnancy, we have informed the MBRRACE-UK, the national Confidential Enquiry team, who record and review all pregnancy-related deaths; they may be in touch to request copies of notes relating to the mother's care. [*If the death has been reported to an investigatory body e.g. Maternity and Newborn Safety Investigations, England, insert the details here*].

The baby [*insert the baby's name*] [*provide clinical information about the baby's outcome, sex, weight and state of health, and plans for discharge if known*].

This has been a very difficult time for [*insert partner's name*] and the family, and I would be grateful if you would ensure that any necessary compassionate leave or absence from work is supported.

The trust is committed to ensuring we learn the necessary lessons from all unexpected outcomes and we will be holding a review of events on [*a date to be arranged*]. You would be welcome to participate in this review if you are able to attend.

A follow up visit with myself has been arranged for [*insert partner's name*] on [*insert date*]. It may be that all the information is still not available at that time, or events are still too painful to review at that date and we will schedule any further follow-up at a time and place that is comfortable for them. [*Insert partner's name*] who is [*name*] partner has my contact details and the contact details of my colleague [*inset name and position*] and I have indicated that we will do our best to answer any questions that they or you may have.

I will be in touch again when we have any further information about the cause of death, the outcome of the local review/investigation of care and in the event that an inquest is called.

Yours sincerely

[*insert name*]

[*insert title*] [*insert contact details*]

Clinical protocol governance and approval

Owner	Seb Adamson, Frank Usifo
Author/further information	David Utting, Consultant Obstetrician
Protocol version	v1.0
Related policies	None
Related documents	None
Standards	RCOG Managing Events Surrounding a Maternal Death and Supporting the Family and Staff; Good Practice Paper No. 18 February 2024 MNSI Maternity and Newborn Safety Investigations MBRRACE (Mothers and Babies: Reducing Risks through Audit and Confidential Enquiries) Ockenden Report Final 2022 https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour
Superseded documents	CG1190 Maternal Death MP076 Maternal Death
Review due	1st April 2028
Date uploaded	1st April 2025

Approval

JOGG	**Date approved:**	26th February 2025
W&C Clinical Effectiveness Group	**Date approved:**	20th March 2025

Consultation

Head of Mortuary	**Date approved:**	23rd October 2024

Ratification

Clinical Document Approval Group	**Date approved:**	1st April 2025

Protocol version control log

Version	Date	Author(s)	Comment
1.0	May 2024	David Utting, Obstetric Consultant	New Trust wide clinical document replacing: • CG1190 Maternal Death • MP076 Maternal Death