Royal Cornwall Hospitals NHS Trust

Policy Under Review

Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

Information Category	Detailed Information
Document Title:	Maternal Death Clinical Guideline V2.0
This document replaces (exact title of previous version):	Maternal Death Clinical Guideline V1.2
Date Issued / Approved:	December 2021
Date Valid From:	January 2022
Date Valid To:	July 2025
Author / Owner:	Ms Sophie Haynes; Obstetric Consultant
Contact details:	01872 252684
Brief summary of contents:	This Guideline gives Guidance to all Obstetricians and Midwives on the process and procedure for all maternal deaths.
Suggested Keywords:	Death, maternal
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Tamara Thirlby
Links to key external standards:	MBRRACE

Information Category	Detailed Information
Related Documents:	MBRRACE-UK: Saving Lives, Improving Mothers' Care. RCOG Green-top Guideline No.56.
Training Need Identified:	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/ Midwifery and Obstetrics

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Maternal Death Clinical Guideline

V2.0

January 2022

1. Aim/Purpose of this Guideline

1.1. The purpose of this Guideline is to assist professionals working within the Trust to firstly recognise that a maternal death has occurred and secondly ensure that the appropriate people have been notified. MBRRACE require all deaths of pregnant women and women up to one year following the end of the pregnancy (regardless of the place and circumstances of the death) to be reported to them.

1.2. **Definition of a Maternal Death**

1.2.1. **A Pregnancy – related** death is defined as deaths occurring in women while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death.

1.2.2. A **Direct** maternal death is defined as a death resulting from obstetric complications of the pregnant state (pregnancy, labour & puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

1.2.3. An **Indirect** maternal death is defined as a death that results from previous existing disease, or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy.

1.2.4. A **Coincidental** death is defined as a death that occurs from unrelated causes which happens to occur in pregnancy or puerperium e.g. road traffic accident.

1.2.5. A **Late** death is defined as a death that occurs between 42 days and one year after abortion, miscarriage or delivery that is due to direct or indirect maternal causes.

1.2.6. A maternal death may therefore include those women who die following a miscarriage, termination of pregnancy, suicide from postnatal depression, death from cardiac disease or any medical disorder, ectopic pregnancy, following a surgical procedure and even following a road traffic accident. (International classification of disease and causes of death, ICD9/10)

1.3. **Roles and Responsibilities**

1.3.1. **Head of Midwifery**

The Head of Midwifery will:

- Ensure there is a guideline in place for the management of maternal deaths which is line with national guidance and legislation.
- Ensure there is a designated local MBRRACE co-ordinator within maternity services.
- Ensure that all maternal deaths are notified to MBRRACE. It is the responsibility of the hospital, NHS Trust or Health Board where the mother and / or baby died to notify the case to MBRRACE. If the

death occurred in a community setting it would be the responsibility of the hospital where the mother's body was taken to after they had died to notify the case to MBRRACE.

1.3.2. Consultant Obstetricians

The consultant obstetricians will:

- Ensure that all medical staff are aware of their responsibilities within the guideline.
- Ensure all medical staff involved in a maternal death are supported.
- Ensure that the guideline is followed
- Ensure that all maternal deaths are notified to MBRRACE
- Meet with the next of kin at the earliest opportunity

1.3.3. Shift Coordinator/Midwife in charge will:

- Ensure the appropriate people are informed (see appendix 3)
- Determine if the next of kin wish any religious or spiritual support to be offered by the hospital chaplain.
- If the mother dies in the Emergency Department or another location in the hospital then a midwife should be present to provide pastoral care to the family.
- Allocate an experienced member of staff as main point of contact for the family to reduce conflicting information until the patient safety midwife take over this role.
- If the baby is a live birth: consider who has parental responsibility (gain advice from on-duty social worker). Refer to the named midwife for Safeguarding and if appropriate MARU.

1.4. In the case of maternal death:

- The MBRRACE co-ordinator (Bereavement Midwife/Head of Midwifery) will contact MBRRACE to request a confidential enquiry form (contact details see Appendix 1). The Local MBRRACE co-ordinator will complete the enquiry form providing contact details for the relevant clinicians. A copy of the medical records will also be sent to MBRRACE at this point by registered post.
- Provide support, information and advice to the bereaved relatives and act as single point of contact within the Trust.
- Provide support, information and advice to staff involved with a maternal death.
- Sign post relatives and staff to other support services.

1.5. **Consultants in other care groups**

All consultants in the Trust will:

- Inform the duty consultant obstetrician and Head of Midwifery of any maternal death which occurs in a department in the Trust other than maternity.

1.6. This version supersedes any previous versions of this document.

1.7. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals (NEW 2020).

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. **Procedure following a maternal death**

2.1.1. Refer to check list and flow chart regarding maternal death (see attached checklist appendix 3) to ensure all necessary actions are taken and recorded.

2.1.2. The woman's case notes need to be photocopied and the original marked 'Please return to lead clinician', as the local MBRRACE coordinator will require a copy for the enquiry into the maternal death.

2.1.3. If the death occurs within the maternity unit and was expected, the appropriate member of the medical team must promptly and

accurately complete a death certificate. The mortuary department should be informed that a maternal death has occurred and to expect the patient. Refer to the Last Offices guidance contained in the Guideline for Staff Responsible for Care After Death, which is available on the intranet under clinical policies and protocols and then Trust wide.

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

2.1.5. 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. Instruct staff that the Coroner's office or equivalent (usually a policeman) may insist on being present when the relatives visit the body.

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

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

2.1.8. In the event of the baby dying in the uterus the following should be noted: 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 death. This is because the post mortem is being carried out on the mother rather than the baby. Therefore registration of a baby in these circumstances over 24 week's gestation as a death is not legally required. This advice has been provided by the Registrar General (Office for National Statistics). However, consideration must be shown to family and explanations given.

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

2.1.10. If a dead baby has been removed during the mother's post mortem please refer to the bereavement midwife for advice who will discuss the next of kin's wishes regarding burial or cremation of the baby with or without the mother.

2.1.11. Whenever a maternal death occurs a Datix should be completed. An initial incident report will be completed and submitted to the Executive Panel.

2.1.12. Once the local MBRRACE co-ordinator has been notified she/he will liaise with the appropriate professionals.

2.1.13. MBRRACE will contact the relevant clinicians requesting further information on the case.

2.1.14. The enquiry form is supported by detailed guidance on how to complete. The information contained in these forms is collated and anonymised by MBRRACE, for publication in the triennial report on Maternal Deaths in the United Kingdom.

2.1.15. Staff involved in the case will require support not only at the time of the maternal death but for some time after the event. Help is available through Human Resources, staff counsellors, Professional Midwifery Advocates and clinical managers.

3. Monitoring compliance and effectiveness

Element to be monitored	• The audit will take into account the record keeping by Obstetricians, Midwives, Nurses and Anesthetists. • The audit will be registered with the Trust Audit Department
Lead	• Bereavement midwives
Tool	See Appendix 4 - Guideline Audit Tool
Frequency	Following every maternal death
Reporting arrangements	• A formal report of the results will be received over the lifetime of this Guideline at the Patient Safety Forum or Clinical Audit Forum as per the audit plan. • During the process of the audit, if compliance is below 75% or other deficiencies identified this will be highlighted at the next Obstetric Patient Safety Forum or Clinical Audit Forum and an action plan agreed.
Acting on recommendations and Lead(s)	• Any deficiencies identified will be highlighted at the next Patient Safety Forum or Clinical Audit Forum and an action plan developed. • Action leads will be identified and a time frame for the action to be completed by. • The Action plan will be monitored by the Patient Safety Forum or Clinical Audit Forum until all actions are complete.
Change in practice and lessons to be shared	• Required changes to practice will be identified and actioned within a time frame agreed on the action plan. • A lead member of staff will be identified to take each change forward where appropriate. • The results of audits will be distributed to all relevant staff via the Patient Safety Newsletter or other appropriate route.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Maternal Death Clinical Guideline V2.0
This document replaces (exact title of previous version):	Maternal Death Clinical Guideline V1.2
Date Issued/Approved:	02 December 2021
Date Valid From:	January 2022
Date Valid To:	January 2025
Directorate / Department responsible (author/owner):	Ms Sophie Haynes, Obstetric consultant Maternity and obstetrics
Contact details:	01872 252684
Brief summary of contents:	This Guideline gives Guidance to all Obstetricians and Midwives on the process and procedure for all maternal deaths.
Suggested Keywords:	Death, Maternal
Target Audience:	RCHT: Yes CFT: No KCCG: No
Executive Director responsible for Policy:	Medical Director
Approval route for consultation and ratification:	Maternity Guidelines Group Care Group Board
General Manager confirming approval processes:	Mary Baulch
Name of Governance Lead confirming approval by specialty and care group management meetings:	Caroline Amukusana
Links to key external standards:	MBRRACE
Related Documents:	MBRRACE-UK: Saving Lives, Improving Mothers' Care RCOG Green-top Guideline No.56
Training Need Identified?	No

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
14 Nov 2018	V1.0	Initial Issue	Angela Whittaker, Matron Acute Maternity Services.
November 2020	V1.1	Addition to section 2.8 regarding gaining consent from the NOK to perform a post-mortem/cytogenetic testing on the baby if the coroner declines a coroners post mortem.	Maternity Bereavement Team
January 2021	V1.2	Following HSIB report recommendations: Addition to the section 1.3.3 asking for a member of the midwifery staff to provide pastoral support to the family and Appendix 3, line 1 for senior staff to oversee the process.	Maternity Bereavement Team
December 2021	V2.0	Full review. No major amendments noted.	Ms Sophie Haynes Obstetric consultant

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity & Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Maternal Death Clinical Guideline V2.0
Directorate and service area:	Obs & Gynae Directorate
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Josie Dodgson, Matron Acute Maternity Services
Contact details:	01872 252684

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This guideline gives guidance to all Obstetricians, Obstetric Anaesthetists, Midwives and Delivery Suite Nurses on the process and procedure for Maternal Deaths
2. Policy Objectives	To ensure that all necessary staff are aware of the correct management of a maternal death.
3. Policy Intended Outcomes	Correct and sensitive management of a maternal death.
4. How will you measure each outcome?	Compliance Monitoring Tool
5. Who is intended to benefit from the policy?	All maternal deaths
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No

Information Category	Detailed Information
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Maternity Guidelines Group Obstetrics and Gynaecology Directorate Meeting
6c. What was the outcome of the consultation?	Guideline agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:**

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	Yes	
Sex (male or female)	Yes	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	Yes	
Race	Yes	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	Yes	
Religion or belief	Yes	
Marriage and civil partnership	Yes	
Pregnancy and maternity	Yes	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	Yes	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: **Josie Dodgson, Matron Acute Maternity Services**

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Tasks to be completed & personnel to be notified

Personnel to be notified	Once completed sign, print and designation Date	Comments
1 Ensure Head of Midwifery, On Call Manager, and Clinical Director and on call Consultant Obstetrician are all informed and are aware that they should oversee the process.		
2 Inform key personnel within the Trust – Chief Nurse and Medical Director and if out of hours the on call Director.		
3 Notify lead bereavement midwife.		
4 Communication with MBRRACE is initiated.		
5 Photocopy complete set of medical records including antenatal records and pathology reports, CTGs and ECG if applicable.		
6 Inform Coroner's office via Switchboard 24/7.		
7 Inform General Practitioner.		
8 Inform Community Midwife.		
9 Inform Health Visitor.		

Personnel to be notified	Once completed sign, print and designation Date	Comments
10 Inform Social Services if required for baby.		
11 Advise all staff involved that witness statements will be required.		
12 If a student midwife has been involved in any aspect of care, the Lead Midwifery Educator at the university must be informed.		
13 Inform the mortuary that the body may be sent without a death certificate (if referred to coroner).		
14 Inform the Trust communications team via 3216.		
15 Inform the Head of Midwifery in the Trust where the woman was booked (if applicable).		
16 Ensure all future booked hospital appointments are cancelled.		
17 If no post-mortem on the baby requested by the coroner then a discussion needs to be had with the next of kin to offer post mortem/cytogenetics. The placenta should be sent for histology.		

Appendix 4. Monitoring Compliance and Effectiveness

Guideline Audit Tool

Applicable Guideline	Maternal Death Clinical Guideline V2.0 December 2021
Audit Register Number	(For audit use)
Process	Retrospective
Audit Date	(For audit use)
Auditor	(For audit use)

	Audit Questions
1	Was the maternal death expected?
2	Was the death a pregnancy-related death?
3	Did the death occur within a maternity setting?
4	In the case of an unexpected maternal death or where the cause of death is unknown, was the Coroner informed?
5	Did the maternal death also result in the death of the baby?
6	Was the maternal death reported appropriately using the DATIX system?
7	Were all key personnel, (as identified by Appendix 3 notes 1-3), informed of the maternal death?
8	Did the Head of Midwifery, within their role as MBRRACE co-ordinator, inform MBRRACE of the maternal death?
9	Were all other relevant personnel (as identified in Appendix 3 notes 9-19) informed of the maternal death?
10	Was a complete set of medical records photocopied where applicable?