Worcestershire Acute Hospitals NHS Trust

Policy for use by health professional involved with cases of maternal Death

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Key Documents Owner/Lead:	Dr Hillman	Consultant Obstetrician
Approved by:	Maternity Governance Meeting	
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Key Amendments

Date	Amendments	Approved by
4th June 2024	Document extended for another 12 months whilst under review	Maternity Governance
24th October 2025	Document reviewed and approved for 12 months	Maternity Governance Meeting

Introduction

The purpose of this guidance is to assist professionals working in both primary and secondary care to ensure effective management in the rare event of a maternal death.

Professionals who are involved in providing both primary and secondary care play an important role in participating in the ongoing Maternal Death Enquiry such as MBRRACE (Mother and Babies Reducing Risk through Audits and Confidential Enquiries) recognising that a maternal death has occurred and, secondly, by ensuring that the appropriate people have been notified.

Definitions of Maternal Death

Direct	Deaths during pregnancy or up to 6 months following delivery, termination or abortion resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above e.g. thrombosis.
Indirect	Deaths during pregnancy or within 42 days of delivery, termination or abortion resulting from previous existing disease, or disease that developed during pregnancy and which was not due to obstetric causes, but which was aggravated by the physiological effects of pregnancy e.g. cardiac disease.
Coincidental	Deaths during pregnancy or within 42 days of delivery, termination or abortion from unrelated causes, e.g. road traffic accidents (RTA).
Late	In addition, the following deaths should be notified if they occur from 42 days to 6 months following delivery, termination or abortion: • Direct deaths (see definition above) • Deaths due to peripartum cardiomyopathy • Deaths due to suicide • H1N1 cases where diagnosis was confirmed during pregnancy or within 42 days of TOP, miscarriage or delivery.

Recognising a Maternal Death

1. The International Classification of Diseases (ICD) definition of a Direct, Indirect, or Coincidental maternal death is one, which occurs during or up to 42 days after a termination of pregnancy, miscarriage, ectopic pregnancy or delivery. In addition, the ICD recognises late maternal deaths, which occur between 42 days and six months after delivery and are also subject to Enquiry and,

therefore, require reporting. Thus, it is apparent that a maternal death may occur in a multitude of both clinical and non-clinical settings.

2. A maternal death may include those women who die following a miscarriage, termination of pregnancy, suicide from post-natal depression, death from cardiac disease or any medical disorder, ectopic pregnancy, following a surgical procedure and even following a road traffic accident. It often includes women who die in Intensive Care Units (ICU) from conditions such as Adult Respiratory Distress Syndrome (ARDS) or Haemolysis, Elevated Liver Enzymes and Low Platelets (HELLP), which develop as a result of the predisposing cause.

A maternal death may therefore occur in the community or in the hospital. The CMACE Coordinator of the district in which the death occurred starts the Enquiry. The responsibility for notifying the Director of Public Health that a maternal death has occurred rests with either the Consultant, Midwife or General Practitioner who had overall responsibility for the pregnancy or the Consultant or General Practitioner treating the woman during her final illness if the death occurs within one year following the end of her pregnancy. It does not matter if more than one professional notifies the Director of Public Health, as case awareness is more important than duplication of notifications.

The local Co-ordinator *must* be informed *immediately* on discovery of a maternal death.

The designated local Co-ordinator for Worcestershire is the Supervisor of Midwives or Manager on call contactable via switchboard at either Worcester Royal Hospital 01905 760760

She will then act as co-ordinator for the maternal death, informing all the relevant personnel.

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
Checklist for use by Supervisors of Midwives/Designated Managers in the event of notification of a Maternal Death with Worcestershire

Please attach patient sticker here or record:

Name: ……

Unit No: | | | | | | | | | | |

NHS No: | | | | | | | | | | |

D.O.B: ……/……/…… *Female* *Cons:* ……

Ensure documentation completed and photocopy all relevant notes as soon as possible (to be kept by Supervisor of Midwives or senior manager in an appropriate/secure place).

	Name	Date	Time
Supervisor of Midwives informed by:			
Head of Midwifery Informed by:			
Clinical Director Informed by:			
Executive on call informed by:			
Inform on-call Obstetric Consultant –to meet with family as soon as possible (if applicable).			

Inform On-call Pathologist – all cases if **cause of death unknown.**
Do not disturb body i.e. **leave all** catheters etc. in situ **until** Pathologist gives alternate advice. N.B. body can be moved to mortuary.
Inform Pathologist of key clinician to contact for further information.

Date	Time

Inform Mortuary Department
Inform following departments to save all related samples
as they may be required by pathologist.
- Path Lab
- Microbiology
- Biochemistry

Date	Time

Inform named Consultant as soon as possible (if applicable).

Date	Time

Nominate suitable member of staff
to support woman's family and act as family's direct contact
(e.g. another Supervisor of Midwives, manager or Ward Manager)

Name of Contact

Inform Coroners Officer

Alexandra Hospital ext. 42045 (01527 512045)
Worcestershire Royal Hospital (01905 338762)

Coroners Office Infomed			
Yes	No	Date	Time

Kidderminster 01562 820888 (Coroners Officer based at Police Station)
Out of hours advice can be sought via West Mercia Police.
Coroners Office will decide if Coroner needs to be informed (usually if cause of death unknown).

Obtain permission for post-mortem
(On-call Consultant to discuss with family)

Post Mortem consent obtained	Date	Time
Yes / No		

Incident Form completed? Datix Web number ……..

Yes	No

On call midwifery manager to inform on-call Hospital Manager and Director of Nursing/Chief Executive

Date	Time

Seek support for staff involved: -

- Other Supervisor of Midwives
- Chaplain
- Personnel Department, etc.

If the family agree, contact their religious representative or the Hospital Chaplain to support family.

N.B. If the woman was still pregnant at time of death, the baby dying in utero **cannot** be registered as a stillbirth, therefore, a stillbirth certificate **cannot** be issued. Please treat relatives with **consideration** at this time *(Ref: Registrar Births/Deaths, London).*

If the baby is removed from the mother's body at post mortem also follow Policy for pre 24/40 pregnancy loss **but inform CMACE**

CEMACH informed	
Yes	No

Inform Julie Maddocks, North West Regional CMACE Unit, Research Floor – 5th Floor, Oxford Road, Manchester, M13 9WL
Tel: 0161 701 6915 email: Julie.Maddocks@cmac.org.uk

Information to be provided:

- 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
- Pregnancy outcome
- Obstetric Consultant
- Short details of the case

Date	Time

- Inform named Community Midwife (if applicable).
- Inform named G.P.
- Inform Named Health Visitor.

- Supervisor to inform LSA Officer and complete maternal death alert via LSA database
- Inform Communication Officer at earliest opportunity

Death certificate completed as soon as possible by attending Doctor: Consultant Grade.

Completed by:	Date	Time

Death certificate given to family

To Whom	Date	Time

Date given to family to meet with Consultant to discuss post mortem results.

Date & time of appt given	Place (Venue)

The Consultant responsible for completing the death certificate must inform Director of Public Health as soon as possible by telephone and follow up in writing. (Richard Harling 01905 760040) rharling@worcestershire.gov.uk

Date	Time

If booked/treated in other area, inform Senior Midwife and Consultant at that hospital.

Yes	No

Inform Social Services if applicable, i.e. social circumstances, care of live baby, etc.

Yes	No

Clinician identified to co-ordinate completion of Confidential Enquiry Form (requested and form supplied by CMACE Regional Manager)

Name of Clinician

Further advice can be sought from: -

- Director of Public Health Richard Harling 01905 760040

and/or

- LSA Officer Mrs Barbara Kuypers 01527 587602