Mid Essex Hospital Services NHS
NHS Trust

MANAGEMENT OF MATERNAL DEATH	**CLINICAL GUIDELINES** **Register No: 06028** **Status: Public**

Developed in response to:	Intrapartum NICE Guidelines RCOG guideline
Contributes to CQC Standards No	C5a

Consulted With	**Post/Committee/Group**	**Date**
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Professionally Approved By		
Mr Spencer	Clinical Director, Obstetrics & Gynaecology	January 2010

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Author/Contact for Information	Alison Hutchinson, Senior Midwife
Policy to be followed by (target staff)	**Midwives, Obstetricians, Paediatricians**
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Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records 08014 Guideline for fetal blood sampling (FBS) 09042 Guideline for the Antenatal, intrapartum and Postnatal Management of women with pregnancy loss 09046 Guideline for the Completion of the Partogram in Pregnancy

Review No	Reviewed by	Review Date
1.0	Jacinta Freeman	January 2003
2.0	Jacinta Freeman	February 2006

It is the personal responsibility of the individual referring to this document to ensure that they are viewing the latest version which will always be the document on the intranet

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1.0 Purpose of the Guideline

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

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Introduction

3.1 The Confidential Enquiries into Maternal Deaths is a triennial report, which gives an overview of the numbers and causes of maternal deaths in the United Kingdom. The enquiry is meant to be informative and the collated and anonymised information shows where improvements in clinical practice and health systems may help to prevent future deaths. It is therefore important that all cases are notified promptly so that full information on each case is readily available.

3.2 In 2003-2005, 295 deaths were reported to the Enquiry. an increase on the cases reported in the past 3 triennial reports. A number of factors, individually or combined, may account for the lack of decline in maternal deaths. These include newly emerging risk factors and changes in the population of women of childbearing age. Of the 416 deaths, 132 were classified as direct and 163 as indirect. As has been seen in the last 3 reports, the number of indirect deaths again exceeds the number of direct deaths. (Refer to Appendix A)

3.3 Professionals who are involved in providing both primary and secondary care play an important role in participating in the ongoing Confidential Enquiry into Maternal Deaths by first recognising that a maternal death has occurred and secondly by ensuring that the appropriate people have been notified.

4.0 Definition of Maternal Death

4.1 **Maternal deaths:** A maternal death is defined as any death which occurs during or within one year of pregnancy, childbirth, or abortion, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

4.2 **Direct:** Deaths 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.

4.3 **Indirect:** Deaths resulting 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.

5.0 Recognising a Maternal Death

5.1 From the broad definition and because the timescale includes one year following pregnancy, it s apparent that a maternal death may occur in a multitude of both clinical and non-clinical settings.

5.2 A maternal death may include those women who die following a miscarriage, termination of pregnancy, ectopic pregnancy, suicide from post-natal depression, death from cardiac disease or any medical disorder, following a surgical procedure and even following a road traffic accident.

5.3 This policy concerning the management of maternal death should be disseminated locally to the health professionals as listed:
(Refer to Appendix B)

6.0 Responsibility for Reporting a Maternal Death

6.1 A maternal death may occur in the community or in the hospital. Recent changes to the structure of the Confidential Enquiry into Maternal Death (CEMACH) mean that Regional Co-ordinators are now responsible for notifying the DoH of a maternal death. The responsibility for notifying the CEMACH Regional Co-ordinator that a maternal death has occurred, should rest with either the consultant or midwife, or the general practitioner who had overall responsibility for the pregnancy, or by 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. This responsibility may be delegated to the nominated maternal death co-ordinator.

6.2 The minimum information required is:-

- The deceased's name, address, date of birth and date of death
- The likely cause of death
- The place of death

7.0 Managing a Maternal Death – Acute Hospital Setting

7.1 As maternal death may occur in a variety of clinical areas within the hospital setting (for example in intensive care units or accident and emergency departments), it is recommended that a senior midwife or supervisor of midwives is nominated to undertake the role of co-ordinator for maternal death within the whole Trust.

7.2 In the event of a maternal death occurring in a department other than the maternity department, the person in charge of the department should notify the unit co-ordinator for maternal deaths. As stated above, this will usually be a senior midwife or supervisor of midwives.

7.3 The role of the co-ordinator will be both complex and demanding. She must ensure that a record of each part of the procedure that has been followed is maintained. A checklist has been developed for the co-ordinators use. The co-ordinator, where possible, should initially be released from her normal duties.
(Refer to Appendix C)

7.4 An experienced member of staff is nominated to act as supporter to the patient's family and also act as their main point of contact to prevent conflicting information being given.

7.5 The consultant on call will be present or in transit to the unit and will meet initially with the relatives. If the patient already has a named consultant, he or she should be informed when next on duty.

7.6 If a supervisor of midwives has not been nominated to act as co-ordinator, then in accordance with the Local Supervisory Authority Guidelines for Supervision of Midwives the on-call supervisor must be notified that a maternal death has occurred.

7.7 The mortuary department should be informed that a maternal death has occurred and to expect the patient. The mortuary attendant may inform the pathologist on-call. If not, it will be the responsibility of the woman's consultant to do so. A post-mortem should be undertaken in order to confirm the cause of death. The consultant present should seek permission for a post-mortem from the woman's next of kin. If the cause of death is unknown, the coroner is informed and he/she will be responsible for ordering a post-mortem.

7.8 The case notes and all documentation should be completed, photocopied and secured at the first opportunity. It should be noted that the coroner may decide to hold a hearing on the case. If this happens, the case notes and documentation will be sent to the coroner's office

7.9 The local risk management process should be activated and an internal investigation initiated.

7.10 The staff involved in the case may require both professional and personal support. Support may be provided by supervisors of midwives, the Hospital Chaplain, Trust Psychotherapy Department or from personnel. It may be necessary to provide an experienced counsellor for staff.

7.11 In the event of the baby also dying, then the local stillbirth/neonatal death procedure should be followed. Refer to the Child Death Review Policy and to Appendix D.

7.12 The relatives may wish for their local Priest, Vicar, Rabbi, or whoever is applicable to their religious denomination, 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 religious to be with them, the hospital chaplain should be contacted.

7.13 The Trust Chief Executive Officer, the Directorate Clinical Director, and the Patient Safety Manager should be notified when next on duty.

7.14 If applicable, the community midwife (midwives) who were involved in the woman's care should be notified.

7.15 Clinical managers within the Department should be notified when next on duty, in case they receive a query in relation to the case.

7.16 Arrangements should be made for the woman's family to meet as soon as possible with her consultant. At least one further meeting should be arranged for when the results of investigations are available in order for the findings to be comprehensively discussed with the patient's close relatives.

8.0 Health Professionals that should be informed in the Event of a Maternal Death

8.1 The consultant must promptly and accurately complete a death certificate subject to the Coroners involvement. It is appropriate for the relatives to deliver the certificate to the Registrar of Births and Deaths.

8.2 The Coroner should be notified if the cause of death is unknown.(Refer to Appendix B)

8.3 A policeman, known as the Coroner's Officer usually works with the coroner, but may not necessarily be based in the same area.

8.4 In some areas, the Coroner's Officer may insist on being present when the relatives visit the body in the mortuary. Sensitive handling and co-ordination will be required if this situation occurs.

8.5 The consultant responsible for the case must inform the CEMACH Regional co-ordinator that a maternal death has occurred. This may be delegated to the co-ordinator. (Refer to Appendix C)

8.6 If the death of the baby has also occurred, the relevant CEMACH procedure must be followed.

8.7 The patient's General Practitioner and Health Visitor must be informed as soon as possible on the next working day.

8.8 If the patient has been admitted, having been treated or booked in another area, the senior midwife and consultant at that hospital must be informed.

8.9 If the patient was not resident in the hospital's local district, the CEMACH Regional co-ordinator must be informed. They will ensure that the CEMACH co-ordinator in the area of residence is notified.

8.10 If the death has occurred outside the maternity department, the consultant, general practitioner or midwife in charge of the pregnancy should be informed.

8.11 Social Services should also be notified depending on the family's social circumstances, or if a live baby requires care, and/or the family require support.

9.0 Managing a Maternal Death in Primary Care

9.1 The General Practitioner should contact the maternal death co-ordinator at the hospital as soon as possible so that the relevant procedures can be commenced.

9.2 The patient's general practitioner or midwife who has responsibility for the pregnancy will be responsible for ensuring that the CEMACH Regional co-ordinator has been notified. This duty may be delegated to the maternal death co-ordinator.

9.3 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.

9.4 General practitioners should also take action to ensure that staff are alert to identifying a maternal death.

10.0 Completing the Enquiry Form

10.1 It is the CEMACH Regional co-ordinator who has responsibility for obtaining Form MDUK (1) from the Department of Health.

10.2 Each Clinician required to complete the form will be required to do so within three weeks of their receipt of the form.

10.3 The designated co-ordinator will track the progress of the completion of the form. A proforma is attached, which may help this process.
(Refer to Appendix E)

10.4 The maternal death co-ordinator will return the completed MDUK(1) form to the CEMACH Regional co-ordinator within the agreed timescale.

10.5 In order to preserve anonymity and prevent the possibility of a legal sub poena, no photocopies of the confidential enquiry form should be made at any time.

11.0 Where to go for further advice

11.1 Further advice in reporting a maternal death may be sought from the CEMACH Regional Co-ordinator.

11.2 Advice may also be sought from the Regional Assessor.

11.3 The Local Supervising Authority Midwifery Officer will also be able to provide support and advice.

11.4 The local CEMACH co-ordinator will advise on information that is required if the baby has also died.

12.0 Staffing and Training

12.1 All midwifery and obstetric staff must attend yearly statutory training which includes skills and drills training.

12.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

13.0 Infection Prevention

13.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively ‘decontaminate their hands’ before and after each procedure.

13.2 All staff should ensure that they follow Trust guidelines on infection prevention. All invasive devices must be inserted and cared for using High Impact Intervention guidelines to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

14.0 Audit and Monitoring

14.1 The risk management lead will review all risk event forms and complaints. Any immediate training or educational issues relating to lack of compliance with this guideline will be addressed on a one to one basis.

14.2 All incidents and trends analysis will be reviewed at the Maternity Risk Management Group meeting.

14.3 Audit of compliance with this guideline will be undertaken annually in accordance with the Maternity annual audit work plan. The Audit Lead in liaison with the Risk Management Group will identify a lead for the audit.

14.4 All sets of health records will assess compliance with the guideline.

14.5 The findings of the audit will be reported to the Risk Management Group and an action plan developed to address any identified deficiencies. Performance against the action plan will be monitored by this group on a monthly basis.

14.6 A survey will be undertaken by the Lead Midwife for Guidelines and Audit, at least annually, to establish staff awareness of how policies should be accessed and the document management process. Any deficiencies identified will inform the staff training programme.

15.0 Guideline Management

15.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

15.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

15.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

15.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

16.0 Communication

16.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

16.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

16.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

16.4 Regular memos are posted on the 'Risk Management' notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

17.0 References

Lewis, G (2007) The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer-2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. London: CEMACH.

Appendix A

The Management of Maternal Death should be Disseminated Locally to the Health Professionals as listed:

- General practitioners
- Health Visitors
- Practice Nurses
- Community Nurses
- Midwives
- Physicians
- Surgeons
- Supervisors of midwives
- Head of Midwifery
- Coroner/Local Coroner's Officer
- Public Health Directors
- Directorate Managers
- Medical Director of Trusts
- Chief Executive of Trust
- Pathology consultants
- Intensive Care Unit staff
- Obstetricians and gynaecologists
- Accident & Emergency staff
- Hospital Nurses
- Mortuary Department

Appendix B

Actions to be completed in the event of a Maternal Death

Maternal death occurs

Identified Maternal Death Co-ordinator or on-call supervisor of midwives informed

Maternal Death Co-ordinator informs personnel on check list - (Refer to Appendix C)

Maternal Death Co-ordinator nominates member of staff to support family

Obstetric incident/risk management investigation commenced

Staff support/counselling organised
Suggested debriefing before end of shift

Local Stillbirth/Neonatal death procedures initiated i.e. CESDI
Refer to Appendix C

Religious support arranged for family if required

Meeting arranged for appropriate consultant with family

Maternal Death Co-ordinator ensures completion of Confidential Enquiry form

Completed form returned to the Regional CESDI Co-ordinator within agreed time limit of 16 weeks

Appendix C

Maternal Death Information Check List

NAME	CONTACT NUMBER	DATE NOTIFIED	SIGNATURE
East of England Regional CEMACH Manager Carol Hay carol.hay@cemach.org.uk	01223 330 356		
LSA Officer - Joy Kirby	01223-597568 07717 130 003		
Maternal Death Co-ordinator			
Consultant Obstetrician			
Woman's GP			
Woman's Health Visitor			
Head of Midwifery			
Supervisor of Midwives			
Woman's Midwife (if appropriate)			
Coroner's Officer			
Hospital on-call Manager			
Unit Risk Manager			
Trust Chief Executive			
Directorate Clinical Director / Director for Patient Safety			
CESDI Co-ordinator			
Mortuary Department			
On-call Pathologist			
Coroner			
Social Services (when appropriate)			

Appendix D

Information Relating to a Baby who Dies with the Mother

1.0 Definition of a Stillbirth

1.1 The definition of a still-birth as given in section 41 of the Births and Deaths Registration Act 1953 is:-

"Still-born child means a child which has issued forth from its mother after the twenty fourth week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life, and the expression 'still-birth' shall be construed accordingly".

1.2 The act assumes that the mother is alive at the time of the still-birth. There is no provision to register a still-birth which occurs at the time of a post-mortem or at any time after the death of the mother. (General Register Office 1996)

2.0 Parental Responsibility

2.1 Where a child's parents were or have been married to each other at or after the time of conception, they each have responsibility for him - Section 2 (1), as extended by Section 1 of the Family Law Reform Act 1987, section 2 (3). Otherwise, the mother alone has parental responsibility, unless the father acquires it by a Court Order or an agreement under the Act (Section 2).

2.2 Who else may acquire parental responsibility? - People other than parents may acquire parental responsibility by the private appointment of a guardian or an order of the court (a residence order, a care order, an emergency protection order or an order appointing a guardian).

2.3 A guardian may be appointed to take over parental responsibility for a child when a parent with parental responsibility dies.

Appendix E

PROFORMA FOR TRACKING
FORM MDUK (1)

Name of Clinicians Involved	Date sent to Clinician	Signature of co-ordinator	Date form received by clinician	Signature of clinician	Date completed form received by co-ordinator

This form must be completed and sent back to co-ordinator on receipt of form MDUK (1)

This is to ensure that the process is completed within the agreed timescale (3 weeks)