Royal College of Obstetricians & Gynaecologists

Managing Events Surrounding a Maternal Death and Supporting the Family and Staff

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Managing Events Surrounding a Maternal Death and Supporting the Family and Staff

This is the first edition of this guidance. This guidance is for healthcare professionals who care for women, non-binary and trans people.

Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their maternal health and reproductive wellbeing. Services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

1. Purpose

The purpose of this Good Practice Paper is to provide operational guidance for all healthcare professionals in maternity services, and all other specialities supporting partners, families and staff following a maternal 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. While such events are fortunately rare, ensuring that staff know what to do will also ensure that partners, families and colleagues are appropriately supported. Trusts and health boards should use this guidance as the basis to draft their own standard operating procedure.

This paper aims to define a consistent process for the difficulties and concerns around maternal death. While we aim to be as specific as possible, the need for organisations to promote awareness of key legislation to their staff is also highlighted.

2. Introduction and background

In the UK, maternal death is now a rare, but nevertheless, devastating outcome of pregnancy. For over 65 years, the national Confidential Enquiry into Maternal Deaths in its various iterations has been collecting data, reviewing care against national standards and guidelines, educating the professions about the trends and causes of maternal deaths, and making recommendations for improvements in future care. Alongside the national learning, local review of maternal deaths has had an important role in critical evaluation and improvement in the care delivered by individual maternity units and hospitals. National and local learning has doubtless contributed to the ten-fold fall in maternal mortality in the UK from 90 per 100 000 maternities in 1952, to 10.9 per 100 000 maternities in the most recently published triennia (2018–20).[1]

As maternal deaths are now fortunately rare events many hospital staff, particularly in maternity services, will be unfamiliar with the logistical and pastoral processes that need to be followed when a death does occur. A number of studies have shown the adverse impact of traumatic events on clinical and other staff.[2,3] Maternal death can affect staff on a personal and professional level, leading to burn-out and psychological morbidity. This can result in self-recrimination and defensive clinical practice. Attending to the pastoral needs of staff, as well as families, is therefore a critically important part of the process that needs to be followed after a maternal death.[3]

Unanticipated maternal deaths will occur and be managed on delivery suite, birthing unit, obstetric theatre and in the emergency department. These deaths will include many of the cases of direct maternal deaths, for example, sepsis, haemorrhage and thrombosis. In most cases, the baby will have already been born before the woman collapses or a perimortem caesarean section may have been performed as part of the efforts to resuscitate her. The maternity team should also be directly involved in the care of pregnant women or women who have recently given birth who die in theatre, on an intensive care unit (ICU), on the gynaecology ward or elsewhere in the hospital. In recent years, the majority of maternal deaths have resulted from indirect and coincidental causes, and many occur as late deaths after the conventional 42-day period following the end of the pregnancy. Thus, many deaths will occur outside the maternity unit, for example, in specialist medical and surgical settings (stroke, liver, lung and cardiac units), mental health settings and hospices.

3. Who needs to be informed and early actions

In addition to the next of kin and other relatives a wide range of personnel will need to be informed as soon as possible after an unanticipated maternal death has occurred. Who is informed and with what urgency will depend upon the circumstances, place and cause of death. All trusts and health boards should have a list of named individuals in these posts for their organisation. Template checklists are provided in Appendix I.

3.1 Immediate actions following an unanticipated death

In the event of an unanticipated death, everyone on the unit will be affected. Nevertheless, care for other women and families will need to continue; see section 3.1.4 for actions following an anticipated death and section 7 on staff support.

In the event of an unanticipated maternal death, the consultants on call (obstetric and anaesthetic), head of midwifery (or deputy) and a representative of the senior management for the hospital should be informed as soon as possible. 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.

The senior clinicians 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, 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.

Two individuals (obstetric and midwifery) should be nominated as named contacts for the family going forward and their contact details should be provided. Where the death has occurred outside the maternity unit, the lead clinicians may come from different specialties. At this point it is important to verify which member(s) of the family is/are the next of kin and, thus, have a right to be kept informed; this is not always straightforward, especially if the woman and their partner were not married or in a civil partnership.

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.

A senior member of the hospital nursing staff, such as the site manager, will be able to give advice regarding preparing the body (for example, airways especially tracheal tubes, lines and catheters should not be removed if a postmortem is anticipated) and might help coordinate communication with the mortuary staff. Staff arriving for the next shift will be able to help with this. Where the death is unanticipated, consideration should be given to forensically preserving materials connected with the care of the woman, 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. 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 nomination of named contacts will reduce the chances of conflicting information being given. In England, 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.[4]

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

- relatives/next of kin
- consultant obstetrician on call (who should attend the hospital if not already present)
- consultant anaesthetist on call (who should attend the hospital if not already present)
- consultant neonatologist on call (if the baby has been born and transferred to the neonatal unit)
- head of midwifery (or deputy) or senior nurse in charge of the non-maternity setting (who should come in if the death occurs out of hours)
- clinical director (or deputy)
- board member or senior member of the hospital management team
- site nurse practitioner
- mortuary technician.

3.1.1 Actions within 24 hours

A member of the senior medical team should discuss all maternal deaths with the coroner/procurator fiscal within the first 24 hours of the death. It is important to agree which member of staff will have this discussion. If the death has been anticipated for some time a postmortem may not be required, although it may be prudent to discuss the death with the coroner/procurator fiscal. In settings covered by a medical examiner a discussion with them may help improve the discussion/referral to the coroner. If a coronial/procurator fiscal 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.

Case notes (including any downloads/print outs from monitors) need to be photocopied (or scanned onto a secure hard drive) and later made available for the investigating team, those writing accounts of events, the coroner, MBRRACE-UK and the family on request. Where families in England consent to a MNSI, 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's GP
- woman's named midwife/team/booking unit
- woman's named health visitor/team if appropriate
- hospital bereavement services
- other specialist medical staff involved in the woman's care, e.g. cardiac services
- trust/health board risk manager
- maternity unit risk manager
- director of nursing
- coroner/procurator fiscal†
- social services (if appropriate)
- trust/health board communications officer

* Formerly part of the Healthcare Safety Investigation Branch (HSIB), but now hosted by the Care Quality Commission (CQC).
† Should be notified as soon as is reasonably practicable.

- head of litigation and complaints
- the medical examiner (in settings where a medical examiner is available).

3.1.2 Actions within the first week

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

The death should also be reported to the relevant regulator, investigatory bodies (e.g. MNSI in England), commissioners and any other bodies to which the trust or health board is accountable; they may require a copy of the case notes.

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. This confers a need for healthcare services to work together and maintain line of sight during the 1-year postnatal period, after the involvement of obstetric services ends, as MBRRACE-UK will require a copy of the case notes.

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

When a maternal death occurs in early pregnancy, or a pregnant woman 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.

Many women who die do so following a period in ICU. If the death occurs shortly after admission without the prior involvement of maternity staff, then the head of midwifery should be contacted. For women who have been on the ICU for a period of time, the maternity and/or gynaecology team should already be involved in the woman's continuing care and should be informed about the woman's death as a matter of routine.

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'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.

3.1.4 Actions following anticipated deaths

In women 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 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.

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. Although a serious incident investigation may not be necessary, it is best practice to review the whole pathway of the woman'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 her care and the outcome, and to improve care for future women with the same condition.

4. Postmortem and death certification

For many maternal deaths, the cause of death will not be obvious and will require a postmortem to confirm. In many instances of unanticipated maternal death, this will be carried out following discussion with the coroner/procurator fiscal as a medicolegal examination.

Following discussion with the coroner/procurator fiscal, it may be agreed that the coroner/procurator fiscal 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.[5]

A death certificate cannot be issued if a coroner/procurator fiscal 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.

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/procurator fiscal can issue a certificate granting release of the body without the cause of death to allow the funeral to proceed. Once the coroner/procurator fiscal 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. The Ministry of Justice produce a useful guide to coroner services, intended for bereaved people and others affected by a coroner investigation.

5. The baby

In many cases of maternal 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 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, which can be highly sensitive. (Maternal deaths remain rare events and often occur in conjunction with transfer of care between different hospital services and sites, particularly when specialist or tertiary level treatment for conditions is required. There is an onus on the organisations to cooperate and maintain congruent line of sight of their responsibilities across different sites.)

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 father/person with parental responsibilities and those caring for the baby and any siblings, especially in those circumstances where there is little family support.

When the woman has been unwell for some time prior to her 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 can still be involved in the decision making. These discussions are by their nature difficult and distressing, and should involve the lead for safeguarding to ensure they are appropriately conducted and all relevant issues are considered and documented.

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.

6. Family support and bereavement care

In some situations, family support may need to start when resuscitation efforts are underway. If possible, someone should keep the partner and family informed as the resuscitation proceeds to avoid long periods of uncertainty. 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.

Family support and bereavement care following the maternal death should be tailored to each family's needs. 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. Some families may wish to bring in their own religious support either for themselves or to perform appropriate rituals. 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 once she 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. There should be open access for those who wish to attend and staff should be made aware of any special arrangements for the bereaved family, both in the maternity and neonatal setting (if applicable). 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 noted above, two key named contacts should be identified and their details provided to the partner and appropriate family members. These individuals should meet with the partner and family as soon as possible after the death. The role of the key contacts is outlined below. It is important to ensure that the staff involved in the death are also aware of who the key contacts are, how to contact them and their availability. 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 coronial/procurator fiscal postmortem are the responsibility of the coroner/procurator fiscal.

During the course of these early discussions, the partner and family may raise the possibility of organ donation. If the woman died on the ICU, 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.[6] If the woman died elsewhere, advice from ICU 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/procurator fiscal then they will need to be involved in any discussions about organ donation and may not grant permission.

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
- ask the partner and family if they would accept staff members attending the funeral.

The bereavement midwife, where one is available, will be able to provide contact with the hospital bereavement office, as well as providing support in the event of the baby's death. Advice about financial support can be sought from the hospital bereavement and patient support office.

The woman's partner will need as much family support as possible, especially where the baby is being discharged home. Consider asking the wider family to take time off work and involve the GP where this would be helpful. 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 (see Appendix II for an example letter). A letter from one of the key contacts outlining the need for additional time off work for relatives should be offered.

6.1 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. Meetings with the partner and family will enable their perspective of the care provided during pregnancy, birth and postpartum to be discussed and fed into the case review and investigation. In England where the death is eligible for an MNSI and the partner has consented, the ongoing support for the partner and family will be a combined effort from the trust/health board key contacts and the MNSI investigators.

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 hospital, community and mental health trusts/health boards to inform and apologise to patients and their families if there have been mistakes in their care that have led to significant harm.[7,8] 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 from the review or investigation, and/or postmortem report even though the latter may take some time if MNSI conducts an investigation or the coroner/procurator fiscal is involved and an inquest is called.

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. The record of all communications with the partner and family and what they understand of the events surrounding the death should be shared with the review or investigation team.

7. Staff support

When a death occurs on the maternity unit, it not only has a devastating effect on the partner and family and the staff directly involved, but will affect the whole unit. Nevertheless, work has to continue and care needs to be provided for other women on the unit.

7.1 Immediate 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 to ensure that staff are provided with appropriate support.

An immediate (before the end of the shift) team debrief should be arranged and facilitated by a senior member of staff who was not directly involved. This should involve all staff across the service who were involved in the care of the woman and/or the baby, 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. It is important to be able to capture this carefully, and also to remind staff 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. All staff should be reminded of how to access hospital counselling services. In settings where a medical examiner is available, their office should be offered as a safe space in which doctors involved in the death can debrief as part of the discussion with the medical examiner.

7.2 Subsequent staff support

Organisations need to demonstrate awareness of the potential impact of a maternal death on the wellbeing of staff. 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. Students, particularly nursing and medical students, may have only a fleeting involvement with the unit, but may be significantly affected.

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. For revalidation, trainees will need to show evidence of having reflected on such events with their educational supervisor.

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 (in England) 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.

8. Media involvement

Consider if the death will be of interest to the media and the consequent actions that may be required. 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.

9. 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.

Further reading

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References

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Appendix I: Example checklists‡ to ensure key actions are completed for unanticipated maternal deaths.

Contacts and actions: IMMEDIATE

Contacts	Name and contact number	Date notified	Print name
Relatives/next of kin			
Consultant obstetrician/ gynaecologist/anaesthetist on call (to attend hospital)			
Head of Midwifery and Nursing (or deputy) (to attend hospital)			
Professional Midwifery Advocate on call (to attend hospital)			
Clinical director (or deputy)			
Board/management team member			
Site Nurse Practitioner			
Mortuary (technician on call – if out of hours)			
Two experienced members of staff nominated to act as the 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 × 2–3 • If for postmortem – copy to go with mother to mortuary/ coroner/procurator fiscal (in Scotland) • Copy to go the MBRRACE-UK reporter • England: 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			

‡Based on the checklist from Guy's and St Thomas' NHS Foundation Trust.

Contacts and actions: WITHIN 24 HOURS (1 working day)

Contact	Name and contact number	Date notified	Print name
Woman's Link Consultant (maternity)	-		
Director of Public Health			
Integrated Care Board Officer			
Woman's GP	-		
Woman's named midwife	-		
Woman's health visitor	-		
Trust/health board risk manager			
Maternity unit risk manager			
Director of Nursing			
Coroner/procurator fiscal			
Coroner/procurator fiscal	Contact by coroner's office		
Social services if appropriate	-		
Communications officer	Contact by trust/health board risk manager		
Head of Litigations and Complaints	Contact by trust/health board risk manager		
Medical examiner (where relevant)			
Coroner/procurator fiscal/postmortem/death certificate Name of coroner/procurator fiscal informed/discussed case _____ Postmortem: ☐ Coroner ☐ Procurator fiscal ☐ hospital Death certification: ☐ Coroner ☐ Procurator fiscal ☐ hospital			
Other hospital doctors informed (e.g. SLE, diabetes, renal, cardiology) 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/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 II: Template letter for communicating with the GP.

This template letter could also be edited for communication with community services.

Dear NAME

It is with sadness that I write to tell you of the recent death in our unit of *[insert woman's name]*. *[insert woman's 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 woman's 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 *[name and address and nature of relationship]* and explained the events that we believe led to her death.

i) We have reported the death to the coroner/procurator fiscal 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/procurator fiscal's instruction.
iii) Give any information about organ donation, etc.

As *[insert woman's 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/health board *[delete as appropriate]* is committed to ensuring we learn the necessary lessons from all unexpected outcomes and we will be holding a review of events on *[insert date or '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 *[woman's 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]

This Good Practice Paper was produced on behalf of the Royal College of Obstetricians and Gynaecologists by: **Dr Kate Harding FRCOG, London; Dr Sheila MacPhail FRCOG, Newcastle; Professor Sebastian Lucas, London; Dr Nuala Lucas, London; Dr Jane Currie MRCOG, London; Ms Mervi Jokinen, London; Ms Lauren Mosley, London; Ms Michele Upton, London; Ms Phillipa Cox, London; and Professor Jennifer J Kurinczuk FRCOG (Hon), Oxford.**

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[1] from June 2020; [2] until May 2020

The final version is the responsibility of the Patient Safety Committee of the RCOG.

The review process will commence in 2027, unless otherwise indicated.

