Centre for Maternal and Child Enquiries

Improving the health of mothers, babies and children

Maternal Death Enquiry – 2009-11

Information for Trust staff, Coroners, Primary Care Practitioners

Inclusion criteria and guidance for reporting a maternal death to CMACE

The following deaths should be reported to the CMACE regional manager for the place of residence of the woman at the time of her death
(N.B. Republic of Ireland – all maternal deaths occurring up to 1 year following miscarriage or delivery should be notified to the CMACE office, Cork, regardless of cause or definition)

All Direct deaths

Direct deaths: Deaths during pregnancy or within 42 days of 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. This 42 day limit is an internationally recognised standard.

All Indirect deaths

Indirect deaths: 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

Coincidental (fortuitous): Deaths during pregnancy or within 42 days of delivery, termination or abortion from unrelated causes. The term 'coincidental' is now preferred to 'fortuitous' as being more appropriate and sensitive. e.g. road traffic accidents.

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
- 2009 onwards H1N1 cases where diagnosis was confirmed during pregnancy or within 42 days of TOP, miscarriage or delivery

Reporting the death

Deaths should be reported to the CMACE regional manager as soon as possible after the death has occurred.

It may also be helpful for you to take a photocopy of the notes at this stage for future reference (as notes are rarely available when you need them at a later date).

Please telephone the regional office to notify them of the death.
Have the woman's notes with you if possible. You will be asked for the following woman's details:

- Postcode and address
- Date of birth
- Date of death

- Suspected cause of death
- Place of death
- GP name and contact details including post code and telephone number
- Booking hospital
- EDD
- Date of delivery
- Place of delivery
- Pregnancy outcome
- Obstetric consultant
- Short details of the case

The Regional Manager will agree a time to phone you to enable full surveillance data to be provided to the CMACE office. Once these details have been provided the Regional Manager will send you the relevant sections of the MDR1 proforma for you and your colleagues to complete:

Completing the MDR1 enquiry pro forma

A letter will accompany the MDR1 giving details of any specific information required and the date for return of the MDR1 to the regional office.

Where the place of death, place of booking and /or place of delivery were different from each other the regional office will obtain the appropriate information independently from each place of care.

Page 2 of the MDR1 provides you with a checklist of the documentation required to enable the enquiry assessors to make a full and appropriate assessment of the factors leading up to and surrounding the death of the woman. Please send a photocopy of these records when returning the completed MDR1.

Pages 3-6 provide guidance for completion of the MDR1. **Please read this guidance before co-ordinating the completion of the MDR1** as it will ensure you provide the most appropriate details for this woman's type of death and minimise the need for the regional office to contact you for further information at a later date.

Sections 1-4 should be completed for all women – your regional office will agree with you whether you should be responsible for accessing GP information or whether they will take this responsibility on themselves.

Sections 5-16 will be sent as deemed relevant to the individual case. **It is important that it is a clinician who was involved or has direct insight into the care of the woman who completes these sections of the MDR1 proforma** to ensure provision to the Enquiry of the most relevant information and also to allow for the 'self reflection' question to be answered. E.g. If there was anaesthetic involvement in the case it should be an anaesthetist who completes section 13 of the MDR1.

Once the MDR1 is completed and all the requested documentation collated, including where relevant the local/trust serious untoward incident (SUI) review, please return to the regional office.

Alison Miller
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