Maternal Death Checklist

Patient's name: …… **Hospital Number**: ……..

Address:……..

DOB: …… **Date of death**: ……..……...

		Signed	***Date***
1	Informed Immediately : • Head of Midwifery or Deputy – who will nominate a maternal death co-coordinator • Maternity Risk Manager – who will escalate to The Trust's Risk Manager • On-call Consultant • Supervisor on-call • (out of hours) Duty Manager-on-call Notify (when next on duty):- • Chief Executive • Press Officer • Consultant Obstetrician for Risk. • Trust's Litigation Department • Director of Nursing Discuss whether Serious Incident Policy needs to be instigated.	…… …… …… …… …… …… …… …… …… …… …… …… …… ……	…… …….. …….. …….. …….. …… …… …… …… …… …… …… ……
2	Notify the Coroner – 01722 438900	……	
3	The Consultant (or GP –depending on setting) should complete a death certificate if the cause of death is known. Note that a death certificate cannot be issued without first referring the case to the Coroner.	……	
4	Check: • if the pathologist needs to be informed • if the Coroner's officer will need to be present when the body is viewed	…….. ……	…….. ……..
5	The case notes and all documentation related to the woman must be photocopied and a list all the people involved in the care of the woman must be produced.	……	
6	The woman's named consultant (or on-call consultant) must meet with the family as soon as possible		
7	Inform the woman's: • Named consultant • General practitioner • Community midwife • Health visitor	…… …… …… ……	…… …… …… ……
8	**Notifications of maternal deaths** should be made by ringing the Oxford MBRRACE-UK office on 01865 289715	…… …… …… ……	
9	The Local Supervising Authority Officer must be informed as soon as possible on the next working day. Telephone: Helen Pearce (mobile 07827984336)	…… …… …… …… ……	
10	Inform the midwife assessor for maternal deaths. Telephone: Helen Pearce (mobile 07827984336	……	
11	If the woman was not resident in the hospital's local district, the		

	local Director of Public Health will ensure that the Director of Public Health in the area of residence is notified.	……	
12	If the woman has been admitted having been treated or booked in another area, inform:- • Head of Midwifery • Consultant at that hospital	……	
13	Inform any other professionals involved e.g. CPN, substance misuse service or social workers	…… ……	
14	Ensure all clinical documentation is checked and signed	……	
15	Nominated maternal death coordinator to co-ordinate activities and to ensure that the checklist is completed.	……	
16	Ensure a clinical incident report should be completed on-line via Datix web. (to be completed within 24 hours)	……	
17	If a SII has been commissioned, it is the responsibility of the Maternity Risk Manager to ensure that the details are reported on STEIS (Strategic Executive information System)	……	