Mid Essex Hospital Services NHS
NHS Trust

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

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1.0	Jacinta Freeman	January 2003
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1.0 Purpose

1.1 The purpose of these guidelines is to assist professionals working in both hospital and community settings, 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 MBRRACE-UK release: Saving Mothers' Lives report – reviewing maternal deaths 2011-2013

3.1 The UK Confidential Enquiry into Maternal Deaths (CEMD) has represented a gold standard internationally for detailed investigation and improvement in maternity care for over 60 years. It recognises the importance of learning from every woman's death, during or after pregnancy, not only for the staff and services involved in caring for her, but for the family and friends she leaves behind.

3.2 This, the second of the Confidential Enquiry into Maternal Deaths annual reports produced by the MBRRACE-UK collaboration, includes data on surveillance of maternal deaths between 2011 and 2013. It also includes Confidential Enquiries for women who died between 2009 and 2013 focusing on lessons on maternal mental health and substance abuse, thrombosis and thromboembolism, caring for women with cancer in pregnancy or postpartum, homicide and domestic abuse, and improvements identified from investigation of the care of women who died between six weeks and one year after the end of pregnancy.

3.3 In collaboration with MDE Ireland, the report also includes Confidential Enquiries into the deaths of women from these causes in Ireland. Each topic-specific Confidential Enquiry chapter now appears in an annual report once every three years on a cyclical basis. Surveillance information is included for 575 women who died during or up to one year after the end of pregnancy between 2011 and 2013. The care of 248 women was reviewed in depth for the Confidential

3.3 'MBRRACE-UK' is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths.

3.4 The aim of MBRRACE-UK is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services. It is therefore important that all cases of maternal death are notified promptly so that full information on each case is readily available. Reporting is accessible via a secure portal on the MBRRACE –UK website.

3.5 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 Causes and Trends

4.1 Overall there has been a statistically significant decrease in the maternal death rate between 2009-12 and 2011-13 in the UK. Maternal death rates from direct causes continue to decrease, but indirect maternal death rates remain high with no significant change in the rate since 2003. Coordinated action across a wide range of health services is required to address this problem.

4.2 There were no deaths from influenza in 2012 and 2013, which also contributed to the decrease in the overall rate of maternal death in 2011-13. This is mainly due to a low level of influenza activity in 2012 and 2013 (compared to 2009 and 2010) rather than an increase in the uptake of vaccination among pregnant women. Increasing immunisation rates in pregnancy against seasonal influenza must remain a public health priority.

4.3 Thrombosis and thromboembolism remains the leading cause of direct maternal death and cardiac disease the leading cause of indirect maternal deaths. Almost a quarter of maternal deaths occurring between six weeks and one year after the end of pregnancy were due to psychiatric causes.

4.4 Access to and uptake of antenatal care remains an issue amongst women who died. Only a third of women who died received the nationally recommended level of antenatal care.

5.0 Definition of Maternal Death

The tenth revision of the International Classification of Diseases, Injuries and Causes of Death, (ICD 10) defines a maternal death as:

5.1 **Maternal deaths:** A maternal death is defined as 'the death of a woman while pregnant or within 42 days of the end of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.(ICD 10)

5.1.1 This means that there was both a temporal and a causal link between pregnancy and the death. When the woman died, she could have been pregnant at the time, that is, she died before delivery, or within the previous 6 weeks have had a pregnancy that ended in a live birth or stillbirth, a spontaneous or induced abortion or an ectopic pregnancy. The pregnancy could have been of any gestational duration. In addition, this definition means that the death was directly or indirectly caused by the fact that the woman was or had recently been pregnant; either a complication of pregnancy; a condition aggravated by pregnancy or something that happened during the course of caring for the pregnant woman caused her death. In other words, if the woman had not been pregnant, she would not have died at that time.

Maternal deaths are subdivided into further groups as:

5.2 **Direct:** maternal deaths are those resulting from conditions or complications or their management that are unique to pregnancy, occurring during the antenatal, intrapartum or postpartum periods.

5.3 **Indirect:** maternal deaths are those resulting from previously existing disease, or disease that develops during pregnancy not as the result of direct obstetric causes, but which were aggravated by physiological effects of pregnancy

5.4 **Table 1: Definitions of Maternal Death**

Maternal Deaths**	Deaths of women while pregnant or within 42 days of the end of the pregnancy* from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.
Direct Deaths **	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.
Indirect Deaths **	Deaths resulting from previous existing disease, or disease that developed during pregnancy and which was not the result of direct obstetric causes, but which was aggravated by the physiological effects of pregnancy.
Late Deaths ***	Deaths occurring between 42 days and 1 year after abortion, miscarriage or delivery that are the result of Direct or Indirect maternal causes.
Coincidental (Fortuitous) Deaths ****	Deaths from unrelated causes which happen to occur in pregnancy or the puerperium. *This term includes delivery, ectopic pregnancy, miscarriage or termination of pregnancy.
ICD 9 ***ICD 10 ** ICD 9/10 classifies these deaths as Fortuitous but the Enquiry prefers to use the term Coincidental as it a more accurate description. The Enquiry also considers deaths from Late Coincidental causes **(**Taken from CMACE: Saving Mothers Lives 2011)	

6.0 Recognising a Maternal Death

6.1 From the 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.

6.2 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.

6.3 This policy concerning the management of maternal death will be available locally to the health professionals as listed and accessible via the Trust website at 'Policies and Guidelines' (Refer to Appendix B)

7.0 Responsibility for Reporting a Maternal Death

7.1 A maternal death may occur in the community or hospital setting. Recent changes to the reporting structure for notifying MBRRACE-UK mean that within the hospital setting this responsibility lies with the Head of Midwifery and in the community setting with 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 within the hospital setting may be delegated to the Head of Midwifery.

7.2 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

8.0 Managing a Maternal Death – Acute Hospital Setting

8.1 As a 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 the Head of Midwifery and/or supervisor of midwives is nominated to undertake the role of co-ordinator for maternal death within the Trust.

8.2 In the event of a maternal death occurring either in the Maternity Service or in a department other than the maternity department, the person in charge of the department should notify the Head of Midwifery (or her nominated deputy) that a maternal death has occurred. The Head of Midwifery will then notify the Consultant on call, Midwifery Manager and Supervisor of Midwives on call, if the HoM is unavailable to attend immediately, she will designate the responsibility of 'co-ordinator' to the Midwifery Manager or the Supervisor on call, dependant on the circumstances

8.3 The role of the co-ordinator will be both complex and demanding. They must ensure that a record of each part of the procedure checklist has been followed and all relevant professionals have been notified. A checklist has been developed to ensure the co-ordinator follows due process and communicates and engages with not only the family but also the relevant senior members of the Trust, including the CEO and executive lead for the Directorate. Out of hours this will be via the executive director on call.

8.4 The co-ordinator must be released from her normal duties; the Head of Midwifery will resume the co-ordination of the incident once on-site following notification of the incident. (Refer to Appendix C)

8.5 An experienced member of staff, preferably the Head of Midwifery (or nominated Deputy) will act as support and liaison with the woman's family and also act as their main point of contact to prevent conflicting information being given throughout the incident and in the days after it

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

8.7 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.

8.8 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.

8.9 If the cause of death is unknown, the coroner is informed and he/she will be responsible for ordering a post-mortem. The mortuary will be able to advise in regard to informing the

coroner and under which circumstances, where women die in acute settings from a direct cause then the coroner must be informed

8.10 The consultant involved in the woman's death must liaise with the mortuary and coroner in regard to issuing the death certificate.

8.11 It is recognised that a maternal death is rare, the incident co-ordinator should seek advice from either the Head of Midwifery or the Site Co-ordinator for advice in regard to appropriate procedures for laying out the body and transfer to the mortuary.
(Refer to the policy entitled 'Infection prevention – care of the deceased' (11040)

9.0 Starting an Enquiry (Acute hospital setting)

9.1 Once the co-ordinator for the incident has been identified, she must ensure all the personnel listed in (appendix A) are informed, including the LSAMO (appendix A). 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 maternal death co-ordinators use (appendix C). The maternal death co-ordinator must ensure completion of the checklist and communication with all relevant healthcare professionals

9.2 The staff involved in the case will require both professional and personal support. Support may be provided by supervisors of midwives, the Hospital Chaplain, Trust Psychotherapy Department, and Occupational Health or from the HR department. It may be necessary to provide an experienced counsellor for staff. There will be a debrief session arranged with all staff involved in the care of the woman and the Head of Midwifery, Lead Consultant and Co-ordinator of the incident, within one week of the death

9.3 The maternal case notes and all documentation should be completed, photocopied and secured at the first opportunity. The Case notes and associated documentation will be sent to the coroner's office in the event of post-mortem or a case hearing.

9.4 The death will be reported via the DATIX system and the risk management process for a Serious Incident will be triggered, a maternal death on site will initiate an internal RCA investigation with external, independent review participating either through the panel review process or from an independent expert opinion

9.5 A supervisory investigation should be initiated in the event of a direct maternal death. The Investigating Officer for a supervisory investigation will be the Supervisor of Midwives on Call the time the death occurred

9.6 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.

9.7 Specific religious beliefs and practices should be respected .The relatives may wish for their religious leader from their faith 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.

9.8 The Trust Chief Executive Officer, Executive Lead, Clinical Director, and Head of Governance must be notified when next on duty.

9.9 The community midwife (midwives) involved in the woman's care must be notified, this includes women booked that live out of area and have received antenatal/postnatal care by midwives form another trust

9.10 Midwifery Managers within the service must be notified when next on duty, in case they receive a query in relation to the case.

9.11 Arrangements should be made for the woman's family to meet as soon as possible with her consultant and Head of Midwifery. Contact numbers and further meetings should be arranged for the family to discuss ongoing concerns and receive updates in regard to the SI investigation and initial findings, subsequent meetings should be arranged when the results of investigations are available in order for the findings to be comprehensively discussed with the patient's close relatives.

9.12 The LSAMO must be informed the next working day via the LSA website and in person of any maternal death occurring within the provider site or that comes to the attention of the HoM that occurs in the community setting.

9.13 If a woman dies from a genetic or inheritable condition (such as Marfan's syndrome) or potentially inheritable disease such as sudden adult death syndrome (SADS), a follow up appointment should be made for an appropriate time for the family to be offered counselling and screening, if they so wish

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

10.1 A Death Certificate should be completed by the relevant personnel i.e. woman's consultant, general practitioner or Coroner depending on the circumstances of the death. The death certificate will be issued subject to the Coroners instructions and communication. The relatives will be requested to deliver the certificate to the Registrar of Births and Deaths.

10.2 The Head of Midwifery (or nominated deputy) must notify the death to MBRRACE -UK (Refer to Appendix E)

10.3 If the death of the baby has also occurred, the relevant MBRRACE-UK reporting procedure must be followed, this is the responsibility of the Risk Management Midwife and Head of Midwifery

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

10.5 If the patient has been admitted, having been treated or booked out of area, then the Head of Midwifery and lead consultant at the provider hospital must be informed.

10.6 If the death has occurred outside the provider trust or within another department, the consultant obstetrician, general practitioner, midwife involved in the care of the pregnancy should also be informed.

10.7 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.

11.0 Informing the Coroner

11.1 The Coroner should be notified if the cause of death is unknown, suspicious or occurs within 24 hours of admission to hospital and he/she will be responsible for ordering a post-mortem. In some areas, the Coroner's Officer may insist on being present when the relatives visit the mortuary. Sensitive handling and co-ordination will be required if this situation occurs.
(Refer to Appendix B)

11.2 A policeman, known as the Coroner's Officer usually works with the coroner, but may not necessarily be based in the same area but may be involved in cases where cause of death is unknown.

11.3 A list of notifiable coroner's cases is attached at Appendix E, the coroner's officer is available for advice in regards to reporting a maternal death.

12.0 Managing a Maternal Death in Primary Care

12.1 The General Practitioner should contact the Head of Midwifery at MEHT as soon as possible so that the internal processes for notifying senior leads within the organisation; the LSAMO and MBRRACE-UK are initiated, ensuring contact with the coroner throughout the investigation. The Head of Midwifery will then ensure the risk triggers are activated to commence an internal serious incident investigation if this is appropriate and ensure ongoing communication with the family.

12.2 The patient's general practitioner, Head of Midwifery or Lead Midwife for Clinical Governance at MEHT will be responsible for reporting the death to MBBRACE-UK. This duty will be delegated by the Head of Midwifery to the Risk Management Midwife if required.

12.3 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, this is via the Trust internal website if required and all GP practices will be made aware of the Trust's Guideline for managing a Maternal Death, this will be via the Clinical Commissioning Group lead for Maternity Service

12.4 General practitioners should also take action to ensure that all staff working within their practice are aware of the processes related to identifying, alerting and investigating a maternal death.

13.0 Completing the MBBRACE Notification

13.1 Nominated leads for Maternity services have access to the MBBRACE-UK reporting system; these include the Clinical Lead, Deputy Clinical Director, Head of Midwifery and Risk Management Midwife

13.2 The Head of Midwifery (or nominated deputy) will be responsible for reporting a maternal death to MBRRACE; she may delegate this to the Risk Management Midwife. Maternal deaths can be notified directly by ringing the MBRRACE-UK office on 01865 289715.

13.3 Instructions for notifying are found in Appendix G.

13.4 The records of the patient must be secured immediately and a photocopy made of the handheld patient records and those held within the purple folder. In the case of a death in the community, a request must be made to the police for the return to MEHT of the woman's handheld records to enable a full investigation to be completed

14.0 Investigation Process

14.1 A DATIX will be completed and an initial concise report will be discussed with the serious management group to determine the level of investigation required and escalation to the Clinical Commissioning Group (CCG).

15.0 Where to go for Further Advice

14.1 Further advice in reporting a maternal death may be sought from the Head of Midwifery, Head of Governance, and Coroners Office

14.2 MBBRACE-UK must also be advised if the baby has also died.

15.0 Staffing and Training

15.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

15.2 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.

16.0 Supervisor of Midwives

16.1 The supervision of midwives is a statutory responsibility that provides a mechanism for support and guidance to every midwife practising in the UK. The purpose of supervision is to protect women and babies, while supporting midwives to be fit for practice'. This role is carried out on our behalf by local supervising authorities. Advice should be sought from the supervisors of midwives are experienced practising midwives who have undertaken further education in order to supervise midwifery services. A 24 hour on call rota operates to ensure that a Supervisor of Midwives is available to advise and support midwives and women in their care choices.

17.0 Audit and Monitoring

17.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

17.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

17.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

17.6 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

17.7 Key findings and learning points will be disseminated to relevant staff.

18.0 Guideline Management

18.1 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.

18.2 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.

18.3 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.

18.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

19.0 Communication

19.1 A quarterly 'maternity newsletter' is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.

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

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

19.4 Regular memos are posted on the guideline and audit 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.

20.0 References

Marian Knight, Derek Tuffnell, Sara Kenyon, Judy Shakespeare, Ron Gray, Jennifer J Kurinczuk (Eds.) (2015) Saving Lives, Improving Mothers' Care Surveillance of maternal deaths in the UK; December.

MBRRACE- UK www.mbrrace.ox.ac.uk

The tenth revision of the International Classification of Diseases, Injuries and Causes of Death, (ICD 10) (www.who.int/classifications/icd/en/)

Appendix A

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

Via external communication:

- General Practitioners:
- Health Visitors
- Practice Nurses
- Community Nurses
- Coroner/Local Coroner's Officer

Via guidelines on Trust Intranet:

- Midwives
- Physicians
- Surgeons
- Supervisor of Midwives
- Head of Midwifery/Nursing
- On call Managers
- Medical Director
- Chief Executive of Trust
- Pathology Consultants
- Intensive Care Unit
- 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

Head of Midwifery informed
on-call Supervisor of Midwives informed

Nominated internal Co-ordinator informs personnel on check list (Refer to Appendix C)

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

Serious Incident/risk management investigation commenced

Staff support/counselling organised
Suggested debriefing before end of shift and then formal debrief meeting arranged

Local Stillbirth/Neonatal death procedures initiated vie MBRRACE
Refer to Appendix G

Religious support arranged for family if required

Meeting arranged for appropriate consultant with family

Liaison with Coroner and Mortuary

Ongoing communication and support for family

Appendix C

Maternal Death Information Check List

NAME	CONTACT NUMBER	DATE and Time NOTIFIED	SIGNATURE
Head of Midwifery *immediately*	07919555805		
Nominated deputy *if HoM on AL/unavailable*			
SoM on call *immediately*	Via switchboard		
Consultant Obstetrician on call immediately	Via switchboard		
Exec. Director on Call *out of hours - immediately*	Via switchboard		
Exec Lead for W+C *09:00 – 17:00*	Via HoM		
Site Manager *out of hours*			
On-call Pathologist *On advice of on call consultant*	Via Switchboard		
Mortuary Department *immediately*			
MBRRACE-UK *Next day via HoM*	01865 289715		
Woman's Consultant *next working day*			
Woman's GP *next working day*			
Woman's Health Visitor *next working day*			
LSAMO - Joy Kirby *next working day*	01223-597568 07717 130 003		
Woman's Midwife *next working day*			
Coroner's Officer *immediately*			
Coroner *next working day*			
Lead Midwife Clinical Gov. *next working day*			
Trust Chief Executive *next working day*			
Chief Nurse *next working day*			
Head of Governance *next working day*			
Clinical Director *next working day*			
Social Services *when appropriate*			
Other professionals who may have been involved: 1. CPN 2. Substance Misuse 3. Diabetes Team			

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 (24+0) 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 If the birth occurred unattended and there was no lung aeration seen at Post Mortem (PM) and no other circumstantial evidence of life at birth, it should be assumed that the baby was stillborn.

1.3 In all cases where there is evidence that the fetus has died prior to the 24th week of pregnancy, the death should not be notified as a stillbirth. Where there is any doubt about the gestational age at which the fetus died, the default position would be to notify as a stillbirth.

1.4 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

Reportable Deaths: A Brief Guide

A death should be referred to HM Coroner if:

- the cause of death is unknown
- it cannot readily be certified as being due to natural causes
- the deceased was not attended by a doctor during her last illness or was not seen within the last 14 days or viewed after death
- there are any suspicious circumstances or history of violence
- the death may be due to an accident (whenever it occurred)
- there is any question of self-neglect or neglect by others
- the death has occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station)
- the deceased was detained under the Mental Health Act
- the death be due to an abortion
- the death might have been contributed to by the actions of the deceased herself (such as a history of drug or solvent abuse, self-injury or overdose)
- the death could be due to industrial disease or related in any way to the deceased's employment
- the death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred)
- the death may be related to a medical procedure or treatment whether invasive or not
- the death may be due to lack of medical care
- there are any other unusual or disturbing features to the case
- the death occurs within 24 hours of admission to hospital (unless the admission was purely for terminal care)
- it may be wise to report any death where there is an allegation of medical mismanagement
- This note is for guidance only; it is not exhaustive and in part may represent the desired local practice rather than the statutory requirements. If in any doubt, contact the Coroner's office for further advice.

Appendix F

Proforma for Tracking of Requests for Statements and Debrief Meeting for Staff Involved in the Incident

Name of Staff Involved	Code for staff Member	Date letter sent re debrief meeting	Date letter sent re statement request	Confirmation received of attendance at debrief	Date statement received

This form must be completed and retained within the Risk Management File for the SI

This is to ensure that the process is completed within the agreed timescales for reporting and investigating the incident