Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

INSTITUTE OF OBSTETRICIANS & GYNAECOLOGISTS
ROYAL COLLEGE OF PHYSICIANS OF IRELAND

NATIONAL CLINICAL GUIDELINE

BEREAVEMENT CARE FOLLOWING MATERNAL DEATH WITHIN A HOSPITAL SETTING

Acute Hospitals Division,

Health Service Executive

Version 1.0

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Contents

Emergency use of the Guideline

Hospital Management is responsible for providing training in the application of this guideline to all staff in accordance with their role in the organisation. It is recommended that in the event of an acute emergency and if the time available is insufficient to allow for reading of the guideline in its entirety, staff should *refresh* their knowledge by;

- **familiarising themselves with individual staff reporting responsibilities as outlined in Section 13 (Documentation Process), p. 34**
- **staff should follow the chronological order of events as outlined in Section 16 (Check List), p. 42**
- **a check list should be inserted to the front of the mother's health care record (HCR)**
- **each staff member involved in caring for the mother and her family is responsible and accountable for completing, and recording the completion of, tasks within his/her remit**
- **a senior staff member is nominated responsibility for completion of the check list and compiling the relevant documentation**

1. Introduction

A maternal death has far-reaching consequences. It may occur in many settings, e.g. maternity/general/psychiatric hospital, in the home, hospice or clinic. It frequently involves a second death; the death of a baby. Most maternal deaths occur suddenly. Without warning spouses/partners, children and other relatives face a new reality for which there can be no preparation. For many staff, a maternal death may be something they will never witness but for which they must be prepared. The Health Service Executive (HSE) inquiries into maternal deaths in Ireland, as well as incident reports and inquests into recent maternal deaths, have alerted health service providers and users to the impact of maternal death on spouses/partners and families.[1]

A maternal death, described as a 'disaster' (Mander, 2001), is the death of a woman during pregnancy or within the first 42 days of the end of the pregnancy, irrespective of gestation, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (ICD-10). Maternal deaths are further subdivided into *direct* maternal deaths and *indirect* maternal deaths. In its seventh report into maternal death in the UK, the Confidential Enquiries in Maternal Death in the United Kingdom (CEMACH) recommended that the arbitrary cut off point for the definition of a maternal death is unhelpful; that enquiries limited by this definition will miss learning lessons from some important *direct, indirect* and *late* maternal deaths that occur later than this time frame (CEMACH, 2007).

Maternal Death Enquiry Ireland (MDE Ireland) calculates MMR for Ireland using published national data of maternities, i.e. women giving birth to a live or stillbirth with birth weight of ≥ 500g (MDE, 2015).[2] MMR calculated in the UK by Mothers and Babies: Reducing Risks through Audits and Confidential Enquiries across the UK (MBBRACE-UK) is also based on maternities rather than births (MBBRACE, 2015). The MMR in Ireland 2012-2014 was 9.8 per 100,000 maternities or 1 in approximately 10,200 maternities (Maternal Death Enquiry Ireland, 2016). Similarly, the MMR in the UK during the triennium 2012 - 2014 was 8.54 per 100,000 maternities (MBBRACE-UK, 2015).

[1] HSE (2013); HIQA (2013); HSE (2008); *Donegal Daily (*02/03/2016*); Irish Examiner (*20/11/2015,& 28/2/2015); *Irish Independent* (25/11/2015, 03/12/2014, 19/11/2014); *Irish Medical Times (24/03/2015); Irish Times (*21/02/2015, 03/12/2014); *IrishHealth.com* (14/04/2013)*;* The Journal (29/09/2014, 19/04/2013) .

[2] Maternal mortality rates (MMR) are based on maternal deaths due to direct or indirect causes and does not include deaths due to coincidental causes or deaths that occur after 42 post-natal days. It is the practice in most countries to use the number of live births as the denominator for MMR, whereas the number of maternities is used by the UK and Ireland to calculate rates on the understanding that this represents a figure closer to the true number of women at risk (Maternal Death Enquiry, *Report for 2009-2012,* February 2015). Available at https://www.ucc.ie/en/media/research/maternaldeathenquiryireland/ConfidentialMaternalDeathEnquiryReport2009-12.pdf (01 September 2016).

Currently, late maternal deaths (deaths after 6 weeks and within a year of giving birth) are not included in national or international maternal mortality rates (MMR). The corollary of this is that late maternal deaths from conditions that may be aggravated by the pregnancy, e.g. cancer, epilepsy, sepsis, stroke, clots, mental ill-health, substance abuse or domestic violence, are seldom discussed. Pregnancy can trigger cardiovascular disease, aggravate underlying cardiovascular disease or cause specific diseases such as peripartum cardiomyopathy (PPCM) (Sliwa & Anthony, 2016). Deaths from cardiovascular disease, in particular PPCM, frequently occur after the 42 day 'early maternal death' period. Furthermore, it has been noted that 'women from vulnerable populations still have a disproportionate risk of dying prematurely, possibly as a result of the multiple health and social challenges they face'.[3]

The incidence of 'late' maternal deaths in the UK has been reported as 14 per 100,000 maternities. Over a quarter of these late maternal deaths were due to mental health related causes (MBRRACE-UK 2015). In an MBBRACE-UK report that focused on psychiatric causes of maternal deaths, it was found that during the five-year period (2009-2013), 101 women died by suicide; 2 women died from other mental health-related causes and 58 women died as a consequence of substance misuse in the UK and Ireland, either during pregnancy or up to one year after the end of pregnancy (MBBRACE-UK, 2016). 21% occurred during pregnancy or within 42 days of the pregnancy end. A further 79% occurred between 6 weeks and 1 year post partum. Holistic maternity care is a pre-requisite for good maternity care that includes screening for mental ill-health and social disadvantage. In many countries the true incidence of late maternal deaths is unknown and at present difficult to ascertain (Creanga et al., 2014; Thornton et al., 2013; Berg et al., 2010; Horon, 2005). Improvements in the detection of maternal deaths can be enhanced through linking the death certificates of women of child bearing age with livebirth, stillbirths and neonatal death certificates, as also would recording a woman's recent obstetric history in coroners' death certificates.

The HSE and Institute for Obstetrics and Gynaecology acknowledge the importance of providing a comprehensive and evidence-based holistic bereavement care service following a maternal death. A national bereavement care standards development group was established by the National Maternity Implementation Steering Group to develop national standards for bereavement care following pregnancy loss and perinatal death[4], and a national guideline for implementation in the event of a maternal death in a

[3] MBRRACE-UK (2015) *Forward by Professor Sir Simon Wessely*. Available at https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202015.pdf [06 September 2016].
[4] HSE (2016). *HSE Standards for Bereavement Care following Pregnancy Loss and Perinatal Death*. Available at (http://www.hse.ie/eng/about/Who/acute/bereavementcare/standardsBereavementCarePregnancyLoss.pdf [06 September 2016].

hospital setting. Central to the provision of bereavement care is the establishment of Bereavement Specialist Teams (see glossary of terms) throughout the health service.

2. Application of Guideline

The National Guideline for Bereavement Care Following Maternal Death within a Hospital Setting has been developed to improve and standardise bereavement care provided to families in the aftermath of early and late maternal deaths. The guideline development process has been informed by the National Clinical Effectiveness Committee (NCEC) Standards for Clinical Practice Guidance (http://health.gov.ie/wp-content/uploads/2015/11/NCEC-Standards-for-Clinical-Practice-Guidance.-Nov-2015.pdf). Due to limited national and international research-based literature specific to bereavement care following maternal death, and the unfeasibility at this point in time of carrying out a budget impact analysis, it is accepted that this guideline does not fulfil the criteria required for NCEC accreditation. It is recommended that primary research be conducted prior to the revision of this guideline in 2019. In the interim, it is recommended that service providers base their bereavement care on the evidence and recommendations stated in this guideline, and in the *HSE Standards for Bereavement Care following Pregnancy Loss and Perinatal Death* (HSE, 2016).
(www.hse.ie/eng/about/Who/acute/bereavementcare/standardsBereavementCarePregnancyLoss.pdf)

3. Recommendation

Hospital Management is responsible for providing training in the application of this guideline for all staff, in accordance with their role in the organisation. It is recommended that, in the event of an acute emergency, and if the time available is insufficient to allow for reading of the guideline in its entirety, staff should ***refresh*** their knowledge by:

- familiarising themselves with individual staff reporting responsibilities as outlined in **Section 13,** (Documentation Process), p. 34
- staff should follow the chronological order of events as outlined in **Section 16,** (Check List), p. 42
- a check list should be inserted to the front of the mother's health care record (HCR)
- each staff member involved in caring for the mother and her family is responsible and accountable for completing, and recording the completion of, tasks within his/her remit
- a senior staff member is nominated responsibility for completing the check list and compiling the relevant documentation.

4. Rationale

In the event that a pregnant or post partum woman dies, or if her death is understood to be inevitable, partners and families will require immediate bereavement support. The *National Guideline for Bereavement Care Following Maternal Death within a Hospital Setting* is designed to assist staff to swiftly respond to the situation and to provide immediate and long-term holistic and individualised bereavement care to the deceased woman's spouse/partner/next-of-kin, children and other relatives. This guideline will be used to benchmark services provided throughout the health services. It is intended to be used in conjunction with Health Service Executive (HSE), Royal College of Physicians in Ireland (RCPI), Irish Medical Organisation (IMO) and the National Nursing and Midwifery Board Ireland (NMBI) guidelines and standards and with national legislation (see appendices 1 & 2).

5. Purpose

The *National Guideline for Bereavement Care Following Maternal Death within a Hospital Setting* seeks to outline the bereavement care process that will be activated in the event of a maternal death. Its purpose is to promote multidisciplinary staff involvement in preparing and delivering a comprehensive bereavement care plan that addresses the immediate and long-term needs of the bereaved, and encompasses their individual emotional, spiritual and social care following a maternal death.

6. Scope

The scope of this guideline is for maternal deaths. It is intended for application in all cases of maternal death, e.g. in maternity hospitals/units, general hospitals and other community health service settings. The guideline applies to;

- spouses/partners, children and other relatives bereaved by maternal death
- all hospital staff
- primary health care teams.

Irrespective of where a maternal death occurs, the bereavement service in the maternity hospital/unit in which the mother registered for maternity care is available to the family as an option for follow-up bereavement care.

7. Acknowledgements

The HSE would like to acknowledge and thank everybody who assisted in the development of this guideline. In particular, the HSE would like to acknowledge;

- the families and health professionals who advised and informed the members of the Maternal Death Bereavement Care Guideline Development Group
- the expert reviewers who advised on aspects of care and on procedures to be followed in the aftermath of a maternal death
- the members of the Maternal Death Bereavement Care Guideline Development Group. The group membership is listed over.

The HSE would also like to acknowledge the families affected by a maternal death.

Membership of the Maternal Death Bereavement Care Guideline Development Group

The group was composed of multidisciplinary staff from the HSE clinical and administrative Services, Irish Hospice Foundation (IHF) and academia.

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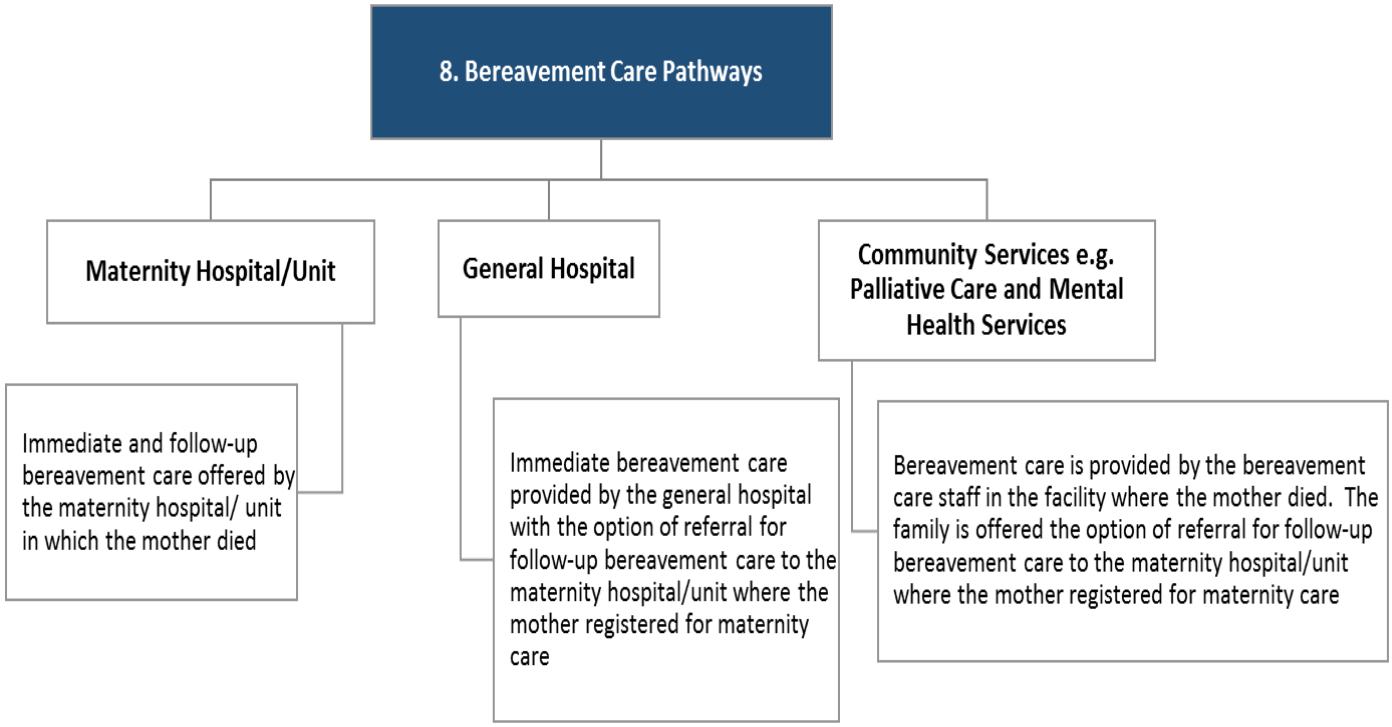
8. Bereavement Care Pathways

Maternal deaths occur in a variety of settings including maternity hospitals/units, general hospitals, the wider community (the home and its environs), mental health services and palliative care services. Staff are advised to follow the care pathways appropriate to his/her work location.



9. Glossary of Terms

Anticipatory Grief

Anticipatory grief describes the normal grief response that occurs prior to death that includes sadness, sorrow, anger, crying and emotional preparation for death (Kehl, 2005). Anticipatory grief differs from conventional grief in so far as it is not infinitely prolonged since there is always an endpoint in death (Sweeting & Gilhooly, 1990). Anticipatory grief is frequently experienced by the patient and her family.

Anticipatory Bereavement Care

Anticipatory bereavement care plays an important role in lessening the intensity of the post-death bereavement experience (Duke, 1998). It is provided to the dying mother and to her family.

Bereavement

Bereavement refers to the objective situation of having lost someone significant through death (Stroebe et al., 2008). Bereavement describes the entire experience of family members and friends in the anticipation of death and subsequent adjustment to living following the death of a loved one (Christ et al., 2003). Bereavement is an experience that is unique and individual (National Clinical Programme for Palliative Care Glossary of Terms, 2012).

Bereavement Care

Bereavement Care is offered to all bereaved persons and provided in accordance with the needs of each individual. It is accepted by bereavement specialists that there are three levels of bereavement care for the general population (Keegan, 2013).

- Level 1 care, also described as 'universal care', involves good care from the point at which the potential for loss is identified. It can encompass end-of-life care and always includes sensitive communication, reliable information and guidance (Aoun et al., 2012; Currier et al., 2008; Walsh et al., 2008). Level 1 care, provides people with information on how to access up to date and useful information about the practical, emotional and other challenges associated with loss. It is compassionate care and should be provided by all who come into contact with the family.
- Level 2 care, also described as 'sensitive' care, is required by people potentially at risk of disenfranchised or complicated grief because of social isolation, demanding caring duties and reduced coping capacity. At level 2, some people may benefit from an opportunity to talk to and receive more formal supports which are often provided by trained volunteers or convened by 'peers' who have had a similar bereavement experience.
- Level 3 care involves professional and therapeutic support. It is required by only a minority of bereaved people and is offered to individuals who are experiencing significant or debilitating difficulties in their bereavement.

Bereavement care staff are trained to assess the bereavement care needs of individuals and to identify people in need of extra support and/or therapeutic care. Staff have in place care pathways for referring relatives to therapeutic services if necessary. Staff acknowledge that this group of people may also incur greater physical and mental health difficulties (Stroebe et al., 2007).

Bereavement Coordinator

The Bereavement Coordinator is responsible for the development, implementation and evaluation of the hospital's bereavement programme. He/she works closely with the CMS in bereavement, chair of the Bereavement Committee, associated professionals and hospital management, and is responsible for ensuring the hospital has capacity and referral systems in place for providing each of the levels of bereavement care. The Bereavement Coordinator has overall responsibility for the educating, training and upskilling all hospital staff in bereavement care.

Bereavement Specialist Team (BST)

The BST is composed of staff members who have undertaken specialist and extensive education in bereavement care. The team includes; a bereavement coordinator, clinical midwife specialist in bereavement, chaplain and senior medical social worker. The team is supported in its work by the hospital chief executive officer (CEO), director of midwifery, clinical leads, obstetricians, paediatricians, neonatologists, perinatal psychiatrist, midwives, nurses, neonatal care nurses, ministers of religions, palliative care teams, bereavement committees, end-of-life care committees, administrative and auxiliary staff, all of whom have received training appropriate to their role in bereavement care.

Care Pathway

A care pathway is a complex intervention for the mutual decision-making and organisation of care processes for a well-defined group of patients during a well-defined period (Vanhaecht et al., 2007). A care pathway is defined and documented in the patient/client's healthcare record (HCR) and is explicit in its goal statement. The care pathway is based on best practice and is discussed and agreed with the patient/client.

Chaplaincy Team

The chaplaincy team includes the officially appointed healthcare chaplains in a healthcare institution.

Complicated Grief

Grief that is complicated involves the presentation of certain grief-related symptoms at a time beyond what is considered adaptive (Kristjanson et al., 2006; Shear & Delaney, 2015). Complicated grief is characterized by intense grief that lasts longer than would be expected according to social norms and causes impairment in daily functioning. Complicated grief is intense and unrelenting since the death of a loved one (Prigerson, 2004). The prevalence of complicated grief has been reported as 10-20% following the death of a romantic partner and an even higher prevalence amongst parents following the death of a child (Meert et al., 2011).

Culture

Culture can be defined broadly as the web of meaning in which humans live (Browning & Solomon, 2005). It is expressed through the characteristics and knowledge of a particular group of people, through their language, religion, cuisine, social habits, music and arts. Culture influences social interactions, cognitive constructs and understanding that are learned by socialisation**.**

Disenfranchised Grief

Disenfranchised grief occurs when grief is not openly acknowledged, socially validated or publicly mourned (Doka, 2002). Bereaved persons who experience disenfranchised grief may require specialised therapies to overcome their grief (Stroebe et al., 2007). Disenfranchised grief inhibits mourners' capacity to overcome suffering and live meaningfully again. Circumstances that expose an individual to the risk of experiencing disenfranchised grief include;

- the relationship is not recognised e.g., non-traditional relationships, affairs, some LGBT relationships
- the loss is not recognised by others e.g., a pregnancy loss, adoption, a termination
- society fails to recognise that a person, such as a child or a disabled person, is capable of grieving
- a death is characterised by stigma – e.g., suicide, substance abuse or involving hidden/secret elements
- a person's response to loss doesn't fit with others' expectations
- a bereaved person denies him/her self the right to grieve because of complexities in a relationship with the person who died e.g., domestic abuse or death of a divorced partner

Grief
Grief is the reaction to bereavement. It is a natural human response that is irrespective of culture and class and its expression varies considerably (Hooyman & Kramer, 2006; Gardner, 1999). The configuration and course of acute grief is different for each person and each loss (Shear & Delaney, 2015).

Hospital
Hospital includes maternity hospitals, maternity units, general hospitals, psychiatric hospitals and hospices.

Interdisciplinary Care
Interdisciplinary care is a patient-centred approach that offers integrated separate discipline approaches into a single consultation (Jessup, 2007).

Maternal Death (MDE Ireland, 2015; MBBRACE, 2014)
A maternal death is the death of a woman while or within 42 days of the end of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Definitions of maternal deaths:

- direct maternal death: a direct maternal death is a death resulting from obstetric complications of the pregnancy state (pregnancy, labour and the puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above
- indirect maternal death: an indirect maternal death is a death resulting from previous existing disease or disease that developed during pregnancy and which was not due to a direct obstetric cause but which was aggravated by the physiological effects of pregnancy
- coincidental maternal death: a coincidental maternal death is a death from an unrelated cause that happens to occur in pregnancy or the puerperium

A late maternal death is the death of a woman from direct or indirect causes more than 42 days but less than one year after the end of pregnancy. Late maternal deaths are not included in maternal mortality rates (MMR).

Maternities
Maternities can be defined as the total of estimated maternities (including live births, stillbirths, miscarriages, ectopic pregnancies and therapeutic terminations). However, available data can be inaccurate and underestimated. In view of this, MDE Ireland calculated MMR using published national data of maternities, i.e. women giving birth to a live or stillborn baby with a birth weight of ≥ 500g (Maternal Death Enquiry Ireland, 2012).

Multidisciplinary Team (MDT)
The MDT is a team of health and social care professionals who apply the skills and experience of their discipline when providing care for their patient. Multidisciplinary teams provide more knowledge and experience than disciplines operating in isolation (Jessup, 2007).

Next-of–kin

The term next-of-kin has no legal definition in Ireland except in inheritance law (Succession Act 1965) where it is defined as the nearest blood relative to the deceased.[5] For the purposes of this guideline, next-of-kin of the mother describes a spouse or nearest blood relative.

Parent

Parent describes a mother, father and other parent.

Staff

Staff includes members of the MDT as well as reception staff, security staff, kitchen staff, midwifery and nursing students, nurse assistants, cleaning staff, porters and all other auxiliary staff in hospitals.

Symbol

A symbol that is recognised by hospital staff and the public is used in maternity units to indicate when an end-of-life issue is happening for a family and/or to indicate that a bereavement has taken place. The symbol selected for use in each hospital is agreed locally by staff and management.

[5] *Succession Act 1965: Updated to 18 January 2016*. Available at http://www.lawreform.ie/_fileupload/RevisedActs/WithAnnotations/EN_ACT_1965_0027.PDF [09 March 2016]]. For additional information see; Eamon Morrissey (*c.*1980). *Probate Practice in a Nutshell*: *a guideline to probate and administration for apprentices and a reference book for practitioners.* E.G. Mongey: Monkstowon, Dublin.

10. Bereavement Care at the time of a Maternal Death

A sudden and unexpected death, such as is a maternal death, can be a devastating experience for spouses/partners/next-of-kin of the mother, children and other relatives. The guideline outlined below has been structured to set out the hospital's responsibilities and actions; to describe the experiences of spouses/partners, children and other relatives in the aftermath of a maternal death, and to outline the essential communication processes that need to take place to support the bereaved at the time of death and afterwards. For the purpose of clarity, you are directed to read across and down the columns as set out below as some processes move sequentially and others in parallel. The importance of having formal structures in place for staff to follow in the event of a maternal death is a recommended priority for hospital management (HSE, 2013; Hill, 2012; McCready et al., 2009; Garco, 2007).

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.1	**Preparing to break bad news** [6]			
10.1.1	Next-of-kin of the mother, as recorded in the mother's Health Care Record (HCR), is confirmed. The senior clinician prepares to discuss all the facts of the mother's care before speaking with the family. The most experienced member of staff is allocated to provide emotional support for the spouse/partner/next-of-kin of the mother and other relatives. He/she selects a quiet private room away from possible interruptions (from people as well as from phones/bleeps).[7] Where appropriate, and in accordance with the family's wishes, members of the multidisciplinary Bereavement Specialist Team (BST) should be involved in the process as soon as possible.	The spouse/partner/next-of-kin of the mother, and other relatives, are aware that the mother is seriously ill and they have been receiving regular and frequent updates on her condition. Social workers are an important resource when supporting families and children in sudden death.	The senior clinician managing the care of the mother liaises with the next-of-kin of the mother as identified in the mother's HCR. The ISBAR tool is used among staff communicating with each other.[8] The HSE Open Disclosure policy is applied in all communication with the spouse/partner/next-of-kin of the mother and other relatives.[9]	*NCEC/HSE (2014); Hollins, Martin & Forrest (2013); Elliott (2012); Reid et al. (2011); Parkes (1998).* *Guidelines in relation to obtaining Clinical Consent in an acute hospital setting.*[10]

[6] Irish Hospice Foundation. *Breaking Bad News* (Short animated video). Available at http://hospicefoundation.ie/education-training/video-wall/communication/ [08 March 2016].

[7] Irish Hospice Foundation. *How do I break Bad News: Information for Staff*. Available at http://hospicefoundation.ie/wp-content/uploads/2013/04/How-Do-I-Break-Bad-News.pdf [26 May 2016].

[8] NCEC/HSE (2014). *Communication (Clinical Handover) in Maternity Services: National Clinical Guideline No* 5. Available at http://health.gov.ie/wp-content/uploads/2015/01/National-Clinical-Guideline-No.-5-Summary-Clinical-Handover-Nov2014.pdf [08 March 2016].

[9] HSE (2013). *Open Disclosure: Communicating with service users and their families following adverse events in healthcare*. Available at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/Open_Disclosure/opendiscFiles/opdiscnationalguidelines2013.pdf [08 March 2016].

[10] HSE (2006). *Guidelines in relation to obtaining clinical consent in an acute hospital setting.* Available at http://www.lenus.ie/hse/bitstream/10147/75681/1/Guidelines%20obtaining%20consent%20to%20clincial%20treatment.pdf [08 March 2016].

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.1.2	The body of the mother is cared for in a culturally sensitive and dignified manner and is prepared for the family to view.[11]			*Hospice UK (2015); HSE (2009); ISANDS (2007).*
10.1.3	In the event of a live-born baby surviving a maternal death, guardianship of the living baby needs to be established. The senior paediatrician sensitively ensures that the baby's legal guardianship is confirmed. In the event that there may be uncertainty about guardianship, e.g. the parents are not married, it is important to seek legal advice at an early stage. In a situation where treatment is immediately necessary to save the life or preserve the health of the new born, the doctrine of necessity would apply and allow/require the clinician to act/provide treatment.[12]		The paediatrician sensitively asks the family to identify the baby's legal guardian.	*Guidelines in relation to obtaining Clinical Consent in an acute setting* (2006).[13] *Children and Family Relationships Act 2015.*[14]

[11] Health Services Executive (HSE) (2009). *Health Services Intercultural Guide: Responding to the needs of diverse religious communities and cultures in healthcare settings*. Available at http://www.tusla.ie/uploads/content/Publication_Health_Services_Intercultural_Guide.pdf [02 March 2016].
Health Services Executive (HSE) (2008). *National Intercultural Health Strategy 2007 – 2012*. Available at http://www.hse.ie/eng/services/Publications/SocialInclusion/National_Intercultural_Health_Strategy_2007_-_2012.pdf [02 March 2016].
[12]Child Care Act 1991. Available at http://www.irishstatutebook.ie/eli/1991/act/17/enacted/en/html [15 April 2016].
[13] Where an unmarried father has, pursuant to an order of the Court, been granted guardianship rights in relation to his child under the Guardianship of Infants Act 1964, as amended by the Status of Children Act 1987 and the Children Act, 1997, then he is entitled to give consent to medical treatment of his child. *Guidelines in relation to obtaining Clinical Consent in an acute setting* (2006). Available at http://www.lenus.ie/hse/bitstream/10147/75681/1/Guidelines%20obtaining%20consent%20to%20clincial%20treatment.pdf. [14 March 2015].
[14]Children and Family Relationships Act, 2015. Available at http://www.irishstatutebook.ie/eli/2015/act/9/enacted/en/pdf [13 June 2016].

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.2	**In the event that the relatives are not present in the hospital at the time of death, the next-of-kin of the mother is contacted by telephone.**			
10.2.1	Staff consider the need for a translator if English is not the spouse/partner/next-of-kin of the mother, or other relatives', first language.		The bereavement support person secures the services of a registered translator.	*Cambridge (2012); HSE (2012),*[15] *HSE (2011).*[16]
10.2.2	The caller (senior clinician managing the care of the mother) introduces him/her self and enquires about the relationship of the person who answers the telephone to the mother. The caller asks to speak to the spouse/partner/next-of-kin of the mother. He/she is informed of the mother's medical condition and the need for him/her to come to the hospital immediately.	The senior clinician sensitively enquires if the mother's legal next-of-kin is immediately available to discuss the mother's condition. The senior clinician must ensure that the urgency of the situation is clearly understood by the next-of-kin of the mother and must sensitively manage the response.	The senior clinician sensitively answers all questions asked by the spouse/partner/next-of-kin of the mother. Consideration is given to the added distress that may be felt after hearing bad news. The spouse/partner/next-of-kin of the mother is advised to contact another family member or friend. With the telephone recipient's permission, staff may contact a family member or friend on behalf of him/her.	*HSE Open Disclosure Policy (2013); Reid et al. (2011); Taylor (2007*); *Wright (1996).*

[15] HSE (2012). *Good Practice Guidelines for HSE Staff in Planning, Managing and Assuring Quality Translations of Health Related Material into Other Languages*. Available at http://lenus.ie/hse/handle/10147/207010 [13 June 2016].

[16] HSE (2007). *National Intercultural Health Strategy 2007 – 2012.* Available at http://www.hse.ie/eng/services/Publications/SocialInclusion/National_Intercultural_Health_Strategy_2007_-_2012.pdf [08 March 2016].

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.2.3	The bereaved spouse/partner/next-of-kin of the mother is advised to contact a relative or friend to transport him/her to the hospital or to travel by taxi. If necessary, staff will offer to send a taxi to transport him/her to the hospital.		Without causing undue alarm, the senior clinician recommends the spouse/partner/next-of-kin of the mother not to drive him/herself to the hospital.	*Parkes (1998); Duke (1998); Wright (1996).*
10.2.4	Child care needs are discussed as required.		The senior clinician enquires if there are children in the house and if an adult is available to take care of them.	*Hospice UK (2015).*
10.2.5	The spouse/partner/next-of-kin of the mother is given the name of a person to ask for when he/she arrives at the hospital, e.g. director of midwifery (DOM) / director of nursing (DON).		It is essential that the person who meets the spouse/partner/next-of-kin of the mother has up to date information about the mother's condition.	*Wright (1996).*
10.2.6	In the event that the next-of-kin of the mother is not contactable, the Garda Síochána can be requested to assist in contacting the family.		The Garda Síochána is apprised of the serious situation and requested to sensitively inform the next-of-kin of the mother that the hospital is seeking to contact him/her. If necessary, the Garda Síochána will assist the family to attend the hospital.	

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.3	**Delivering the bad news in hospital and caring for relatives**			
10.3.1	A suitable quiet and private space, away from the main thoroughfare, with comfortable seating and adequate ventilation and with easy access to bathrooms and refreshments, is prepared for the spouse/partner/next-of-kin of the mother and other relatives (family room).		The invitation to avail of the family room is offered sensitively to the spouse/partner/next-of-kin of the mother and other relatives.	*Hill (2012); Parkes (1998); Wright (1996).*
10.3.2	The BST, or equivalent hospital service, is informed of the woman's death/impending death. In the event that a member of the BST is unavailable, a nominated bereavement support person, e.g. the most experienced nurse/midwife involved in the care of the mother, is freed from other clinical duties for the duration of the family's stay in the hospital in order that he/she can be available to the family. The bereavement support person is introduced to the spouse/partner/next-of-kin of the mother, children and other relatives.	The bereavement support person accompanies the spouse/partner/next-of-kin of the mother, children and other relatives to the family room and remains present with them for as long as needed ensuring their physical needs are also met, e.g. tissues, drinks, easy access to a bathroom.	The bereavement support person informs the spouse/partner/next-of-kin of the mother and other relatives that the doctor responsible for the mother's care will update them on her condition.	*Lundberg et al. (2013); HSE/SCA (2013); Hollins Martin & Forrest (2013); NICE, (2013); Taylor (2005).*

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.3.3	Staff such as reception, switchboard and security staff, are advised to direct all enquiries concerning the mother to the identified bereavement support person. Security and reception staff are alerted to facilitate easy access to the hospital and car parking for the spouse/partner/next-of-kin of the mother.			*Browning & Solomon (2005); Catlin & Canter (2002).*
10.3.4	Consideration is given to the presence of children.	If children are present arrangements are made, with the spouse/partner/next-of-kin of the mother, children's parent/guardian or other relatives, for the children's care while the news is being broken.	The bereavement support person enquires from the children's parent/guardian whom he/she would like to care for the children while he/she speaks with the lead clinician who cared for the Mother. The medical social worker (MSW) on duty is contacted if necessary.	*HSE Standards for Bereavement Care following Pregnancy Loss and Perinatal Death, 2016; Hospice UK (2015).*
10.3.5	The senior clinician, accompanied by a second member of staff, informs the next-of-kin of the mother that she has died.	The spouse/partner/next-of-kin of the mother, and other relatives, are told that the news to be broken is not good. Consideration should be given to whom the spouse/partner/next-of-kin of the mother wishes to have with him/her when first speaking to the lead clinician. If necessary, the extended family can be spoken to later. The spouse/partner/next-of-kin of the mother, and other relatives, are given time to react to the news. Individual reactions to the news are accommodated and facilitated.	Clear, unambiguous and simple language is used to communicate that the mother has died. Time is given for questions to be answered compassionately and sensitively. As the bereaved spouse/partner/next-of-kin of the mother, and other relatives, may not have heard or not processed what they have been told, the information may need to be repeated.	*Lundberg et al. (2013); Hill (2012); Elliott (2012); Taylor (2005); Parkes (1998); Wright (1996).*

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.3.6	If applicable, the paediatrician is requested to be available to meet the spouse/partner/next-of-kin of the mother, baby's parent/guardian and other relatives and to update them on the baby's well-being.	The spouse/partner/next-of-kin of the mother, baby's parent/guardian and other relatives are told about the baby's well-being.	The baby's condition is communicated in clear and simple language.	*Hill (2012); Gold et al. (2007); HFH Standards (2010); ISANDS (2007).*
10.3.7	The bereavement support person confirms with the family the mother's religious/spiritual affiliation as recorded in her HCR.	The spouse/partner/next-of-kin of the mother and other relatives are offered spiritual support in accordance with their, and the mother's, religious, cultural and ethnic beliefs.	Enquiries are made with the spouse/partner/next-of-kin of the mother and other relatives to establish if they wish to be visited by the chaplain and/or a spiritual adviser of their choosing. Consideration is also given to the possibility that the family may wish to have the chaplain bless or pray for the baby.	*NHS (2015); NICE (2013); ISANDS (2007).*
10.3.8	The chaplain on duty is asked to be available should the spouse/partner/next-of-kin of the mother and other relatives wish to speak with him/her.	In the event that a spiritual adviser, in accordance with the spiritual beliefs of the mother, spouse/partner/next-of-kin of the mother and other relatives, is not on site, the hospital chaplaincy team will seek an appropriate spiritual adviser and will offer spiritual support in the meantime.	The spouse/partner/next-of-kin of the mother and other relatives are advised that there may be a delay in the arrival of their nominated spiritual adviser.	*Hollins Martin & Forest (2013*); Gilraine-McGarry & O'Grady (2011).
10.3.9	A symbol signifying that a death has taken place, and recognisable to all, is displayed in accordance with hospital policy and is explained to the family.		The purpose of the symbol is explained to the spouse/partner/next-of-kin of the mother and other relatives.	*HIQA (2016); Irish Hospice Foundation (2015); Williams et al. (2008).*

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.3.10	Staff consider additional bereavement support persons, e.g. other family members.	The bereavement support person enquires from the spouse/partner/next-of-kin of the mother and other relatives if there are additional relatives they would like to establish contact with.	The spouse/partner/next-of-kin of the mother and other relatives are supported in notifying persons they would like informed about the death.	*Stroebe et al. (2007); Duke (1998); Parkes (1998).*
10.3.11	The bereavement support person speaks to the spouse/partner/next-of-kin of the mother and other relatives about seeing the deceased mother and invites them to do so as soon as they are ready. Consideration is given to the provision of an environment that is conducive to dignity, quietness and respect and in accordance with the family's needs.	The spouse/partner/next-of-kin of the mother and other relatives are alerted to what they will observe when they see the mother, e.g. how she will look, if there are tubes in situ or if there will be surgical or medical equipment in the room. The spouse/partner/next-of-kin of the mother and other relatives are promptly facilitated to see the deceased mother and to have as much time as possible with her.	When it is evident to the bereavement support person that the spouse/partner/next-of-kin of the mother and other relatives have understood the significance of what has happened, and what they should expect to see, they are brought to see the deceased.	*Wright (1996); Fraser & Atkins (1990)*

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.3.12	If applicable, the bereavement support person initiates discussion with the children's parent/guardian as to how best to break the news to the children. In the event that children have to be collected from crèches or schools, the bereavement support person will offer to liaise with the person in charge of the crèche or school. If it is the wish of the parent/guardian, the bereavement support person will assist in contacting the nominated family member to bring the children to the hospital. In the event that there is no family support available, a social work referral should be considered.	If requested by the children's parent or guardian, the bereavement support person will be available to play a supportive role when the parent/guardian breaks the news of their mother's death to the children.	The bereavement support person recognises that the needs and comprehension of younger children are different from older age groups. He/she will establish the ages of the children and provide information and literature appropriate to their ages, which will be available in each hospital.	*Ottawa Hospital Research Institute (2015); Machajewski & Krong (2013); Roose & Blanford (2011); Bates et al., (2008); Riley (2003); Walter (2003).*
10.3.13	The bereavement support person sensitively enquires if the children's parent/guardian would like to consider allowing the children see their deceased mother.	Children are facilitated with sensitive and age-appropriate support to see their deceased mother, if so wished by the children's parent/guardian.[17] The family are advised of the optimum time to see their mother. In the event that the parent/guardian declines to have the children see their deceased mother the opportunity will be offered again at a later time.	With the consent of the parent/guardian, the children are asked if they would like to see their deceased mother and they are sensitively informed about what to expect if they choose to do so.	*Rose & Blanford (2011); Christ (2010).*

[17] For general guidance for communicating with bereaved families and developing literature see: http://www.childhoodbereavement.ie/ and http://www.sad.scot.nhs.uk/bereavement/bereaved-children/; http://www.hse.ie/eng/services/list/4/Mental_Health_Services/NOSP/Research/reviewbereavmentsupport.pdf [06 September 2016].

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.3.14	A referral is made to the social work department if the need is identified and following consultation with the family.	Support is provided in making suitable care arrangements for children in the immediate and the longer term. This will involve discussing the parent/guardian's preferences, contacting his/her selected relatives or friends and, if necessary, a medical social worker who will assist in identifying support systems.	Exploration of individual parent/guardian's social circumstances is sensitively managed and a discussion takes place around the availability of informal and formal support networks.	*Hollins Martin & Forest (2013); Lundberg et al. (2013); Stroebe et al. (2007).*
10.3.15	Staff acknowledge the importance of relatives' support for the spouse/partner/next-of-kin of the mother at this time and the possible need for persons other than those present to see the deceased mother before she is transferred to the mortuary.	Where possible, the spouse/partner/next-of-kin of the mother is facilitated to invite the immediate family to see the deceased mother. In consultation with the spouse/partner/next-of-kin of the mother and other relatives, the mother's body is transferred to the hospital mortuary in a sensitive and discreet manner.	The bereavement support person sensitively enquires from the spouse/partner/next-of-kin of the mother if he/she wishes for family members other than those present to attend the hospital to see the deceased mother. Transfer to the mortuary is discussed sensitively with the family. It is explained to the family that an accurate autopsy is best achieved when a body is not detained at room temperature for a lengthy period.	*Parkes (1998); Wright (1996).*
10.3.16	The spiritual/religious/philosophical and cultural needs of the family are considered. Spiritual/pastoral support, in accordance with the wishes of the bereaved family, is offered by the chaplaincy team to the spouse/partner/next-of-kin of the mother/family who may wish to have prayers, a blessing, ceremony or ritual before removal of the remains to the mortuary.	Spiritual support is provided in accordance with the beliefs and customs of the family and in a manner that is culturally sensitive. This support might include ritual/prayer/ceremony as appropriate.	The hospital chaplain ascertains the wishes of the spouse/ partner/ next-of-kin of the mother and family concerning any ritual/prayer/ceremony that is offered. Cultural sensitivities are considered as part of this care.	*HSE Intercultural Guide (2009)*

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.3.17	In the event that the baby has died, consideration should be given to encouraging and empowering the spouse/partner/next-of-kin of the mother/guardian to understand the importance of memory making and collecting mementos of the baby. Staff should be mindful of any personal, spiritual or cultural preferences of the family. The collected keepsake/mementoes should be recorded and presented to the spouse/partner/next-of-kin of the mother/guardian in a gift box at an appropriate time.[18] The bereavement support person identifies when the time is appropriate to initiate a discussion on moving the mother and baby's bodies to the mortuary.	The spouse/partner/next-of-kin of the mother/family are facilitated and encouraged to spend time with mother and baby. The bereavement support person will talk to the partner about creating bonds/memories between mother and baby, e.g. leaving a blanket with both and swapping these prior to the funeral, thus creating a keepsake of the baby.	The spouse/partner/next-of-kin of the mother/family are sensitively told of the option to create mementos, e.g. photographs, I.D. bracelets, clothing and other personal items. Should he/she/they decline to do so another opportunity will be sensitively offered at a later time.	*Burden et l. (2016); Roose & Blanford (2011); SANDS (3rd ed., 2007); ISANDS (2007); Capitulo (2005); Busch & Kimble (2001).*
10.3.18	In the event of a baby surviving after birth, the bereavement support person enquires from the paediatrician if the baby is well enough to join the family for a short period.	Before the mother is transferred to the mortuary, the family are invited to have the baby brought to them, from where he/she is being cared for.	The family are sensitively asked if they would wish to have the baby with them and to create memories with the baby and his/her mother.	

[18] For guidance on the needs of parents following the death or stillbirth of his/her baby see http://www.sad.scot.nhs.uk/bereavement/pregnancy-loss-stillbirth-and-neonatal-death/ [06 September 2016].

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.3.19	The hospital communications department is notified of the death. It is assumed that the media will contact the hospital; in which case, only minimum information is provided as most maternal deaths are subject to a Coronial and Internal Hospital Enquiry. All staff are aware of the potential for media interest in such a sensitive situation and are familiar with the communications policy within the hospital. All enquiries are referred to the media department. Front line staff do not speak to the media and are reminded to maintain patient confidentiality at all times.	The spouse/partner/next-of-kin of the mother and other relatives are informed that the hospital will not release information about the deceased mother to the media. While the family have the right to contact/inform the media of the events if they so wish, their privacy will be protected/respected by the hospital.	The hospital's primary concern is to protect the spouse/partner/next-of-kin of the mother and other relatives from unwarranted invasion of their privacy. Hospital management and staff reassure the spouse/partner/next-of-kin of the mother and other relatives that, while the media may make enquiries, no information identifying the deceased or her spouse/partner/next-of-kin of the mother, children or other relatives will be released, and that confidentiality will be maintained by all staff.	*Media Relations Protocols for HSE Employees*.[19]
10.3.20	A baby who dies in utero, but is not delivered until his/her mother's post mortem, should receive the same care as all other deceased babies.	If they so wish, and with the Coroner's consent, the spouse/partner/next-of-kin of the mother and other relatives are afforded an opportunity to spend time with the baby, and to make memories.	A blessing/naming service with the hospital chaplain may be offered in accordance with the wishes/cultural beliefs of the family.	*Civil Registration Act 2004, sections 19 & 28.*
10.3.21	In the event that a baby has died in utero and is delivered during the post mortem examination, he/she may also require a post mortem examination.[20] Supervised viewing of the baby is facilitated in accordance with the Coroner's enquiry.	Staff must sensitively prepare the spouse/partner/next-of-kin of the mother and other relatives for the appearance of the baby.	If necessary, staff sensitively explain the reasons why there may be a delay in seeing the baby and the reason for the delay, e.g. delay in availability of a pathologist and Coroner's enquiry.	*HSE (2012).*[21]

[19] (HSE). *Media Relations Protocols for HSE Employees*. Available at https://www.hse.ie/eng/services/news/newsresources/commstoolkit/Media_Relations_Protocols.pdf [20 April 2016].

[20] The cause of death will determine if a post mortem will be necessary for the baby. The Coroner will discuss the cause of the mother's death with the pathologist and direct if a post mortem will be necessary or if it will only be necessary to weigh and measure the baby; in which case, the family will be able to take the baby home earlier, should they so wish.

[21] Health Service Executive (HSE) (2012). *Standards and Recommended Practices for Post Mortem Examination Services*. Available at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/Standards/hsestandardsandguidance/PME_services/PM_services_docs/QPSDD0071.pdf [09 March 2016].

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.3.22	Prior to the transfer to the mortuary, the spouse/partner/next-of-kin of the mother/family receive the mother's valuables, e.g. jewellery and money, in accordance with hospital policy.	The person receiving the valuables confirms in writing that he/she has received the items.	Discussion on the mother's valuables is sensitively approached by staff. Documentation involving the valuables is placed in the mother's HCR.	*HSE Patients' Private Property Guidelines.*[22]
10.3.23	All maternal deaths are reportable to the Coroner but a post mortem examination is not always required. In some instances a consented or hospital post mortem may be agreed or requested by the family. Prior to the family leaving the hospital, and provided the spouse/partner/next-of-kin of the mother consented, he/she should be informed where and when the consented/hospital post mortem will be performed and the expected timing of the release of the mother's body to the family. The lead clinician informs the spouse/partner/next-of-kin of the mother that he/she will be in contact when the results of the post mortem are available.	The lead clinician discusses the benefits of a hospital post mortem with the spouse/partner/next-of-kin of the mother. If permission is given, written consent by the spouse/partner/next-of-kin of the mother is taken in accordance with HSE (2012)[23] and RCPI Faculty of Pathology (2000) [24] policies and guidelines. A hospital post mortem is only applicable when the cause of death is known, e.g. malignant disease or if the family requests one. Otherwise a Coroner's post mortem is required.	The spouse/partner/next-of-kin of the mother is advised that there may be a delay of 3-6 months for the post mortem results to be available and that a phone call will be made, or if preferred a letter, will be sent, to arrange an appointment to meet with the lead clinician to discuss the findings. The family should be advised/invited to contact the nominated support person if they wish to meet the lead clinician in the interim, so as to discuss the illness/pathway of treatment or other concerns.	*HSE (2012); RCPI Faculty of Pathology (2000).*

[22] HSE. *Patients' Private Property Guidelines.* Available at https://www.hse.ie/eng/services/publications/corporate/Patients%E2%80%99%20Private%20Property%20Guidelines.pdf [14 June 2016].

[23] HSE (2012). *Standards and Recommended Practices for Post Mortem Examination Services (2012).* Available at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/Standards/hsestandardsandguidance/PME_services/PM_services_docs/QPSDD0071.pdf [26 April 2016]

[24] HSE (2012). *Standards and Recommended Practices for Post Mortem Examination Services (2012).* Available at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/Standards/hsestandardsandguidance/PME_services/PM_services_docs/QPSDD0071.pdf [26 April 2016]

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
10.3.24	If not required by pathology, the mother's other personal belongings, e.g. clothes, are carefully folded in a family handover bag. If it is necessary to temporarily hold personal belongings, the spouse/partner/next-of-kin of the mother is advised when and how these will be returned. The spouse/ partner/next-of-kin of the mother is sensitively informed that if the clothing is soiled it may have to be disposed in accordance with health and safety regulations and documented in the mother's HCR.	Prior to leaving the hospital, the family is offered an opportunity to see the mother's personal belongings; following which, the family receive the unsoiled belongings in a handover bag designed for such a purpose.	The bereavement support person sensitively offers the family handover bag to the spouse/partner/next-of-kin of the mother or other relative.	*IHF (2014).*[25]
10.3.25	The bereavement support person remains available to the spouse/partner/next-of-kin of the mother and other relatives after transfer of the mother's body to the mortuary.	On-going opportunities are provided by the bereavement support person to update the spouse/partner/next-of-kin of the mother and other relatives, and to facilitate any questions they may have. This is done in consultation with the clinical team. Prior to leaving the hospital, the bereavement support person who has been with the spouse/partner/next-of-kin of the mother and other relatives throughout their time in the hospital, ensures that they are provided with verbal and written information relevant to their needs.	The spouse/partner/next-of-kin of the mother and other relatives are given appropriate written information and an essential contact list that includes the contact details for the BST, the mortuary, Coroner's office, agencies and support services and if applicable, the neonatal intensive care unit or ward where the baby is being cared for.	*HSE (2013).*

[25] Irish Hospice Foundation (2014). *The Hospice Friendly Hospitals Programme: overview 2007-2013.* Available at http://hospicefoundation.ie/wp-content/uploads/2013/04/The-Hospice-Friendly-Hospitals-Programme.-Overview-2007-20131.pdf [14 June 2016].

	Hospital	Spouse/partner/next-of-kin of the mother Children, Other Relatives	Key Factors of the Communication Process	Source
10.3.26	Through the senior clinician involved in the care of the deceased and the BST, the hospital will maintain contact with the spouse/partner/next-of-kin of the mother, or other nominated relative, after they have left the hospital.	The senior clinician will contact the spouse/partner/next-of-kin of the mother, or nominated other relative, during the first week after the death to afford him/her an opportunity to ask any questions or express any concerns the family may have.	The bereavement support person informs the family that, with its permission, he/she will be in contact with the family to offer emotional support in approximately 7-10 days. The bereavement support person enquires who should be the point of contact, and how contact should be made, e.g. by phone/letter/email. The spouse/partner/next-of-kin of the mother is invited to initiate contact with the bereavement support person at any time prior to receiving communication.	*HSE Open Disclosure Policy (2013).*
10.3.27	In the event that the death took place other than in the hospital where the mother was registered for maternity care, the news of her death is communicated by the clinical lead responsible for her care at the time of her death to the clinical lead in obstetrics in the maternity hospital/unit.	The spouse/partner/next-of-kin of the mother and relatives are informed that the clinical lead in the hospital where the deceased was receiving maternity care will be told of her death.	It is important to communicate the news of the mother's death to the hospital where she was receiving maternity care so as to ensure that; • staff in the maternity hospital/unit are aware of her death • no communication is sent to the deceased mother in error • the BST in the maternity hospital/unit receives contact details for the spouse/partner/next-of-kin of the mother.	*Kripalani et al. (2007); Gold (2007).*

11. The Role of the Coroner following a Maternal Death

	The Coroner	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
11.1	**All sudden and unexplained deaths must be reported to the Coroner.[26]**			
11.1.1	The Coroner is informed of all maternal deaths. In accordance with local practice, the pathologist is contacted by the Coroner and informed of the need for a CPM. Where a Coroner's post mortem (CPM) is necessary, the Garda Síochána are contacted to complete the formal identification. In some circumstances, and with the agreement of the Coroner, a third party e.g. an undertaker may be required to identify the body to the Pathologist.	The spouse/partner/next-of-kin of the mother and other relatives are advised of the reasons for a CPM examination and that it will be carried out by a pathologist under the authorisation of the Coroner. The spouse/partner/next-of-kin of the mother and other relatives are informed by the lead clinician caring for the mother at the time of her death that formal identification by the Gardaí is required prior to a CPM.	The spouse/partner/next-of-kin of the mother and other relatives are sensitively informed of the need for formal identification of the mother by the Gardaí who in turn will identify the body to the pathologist. Identification is arranged when the spouse/partner/next-of-kin of the mother is ready to do so. If the spouse/partner/next-of-kin of the mother is too distressed to complete the ID it may be completed by an adult relative of the deceased. The spouse/partner/next-of-kin of the mother is given verbal and written information outlining the post mortem and the role of the Coroner.	*Hollins Martin & Forrest (2013); Coroner Service.*[27]

[26] Coroners Act, 1962. Available at http://www.irishstatutebook.ie/1962/en/act/pub/0009/index.html [09 March 2016].
Coroners (Amendment) Act 2005. Available at http://www.irishstatutebook.ie/2005/en/act/pub/0033/index.html [09 March 2016].
[27] Available at http://www.coroners.ie/en/CS/Pages/Reporting%20of%20a%20Sudden%20Death [14 June 2016].

	The Coroner	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
11.1.2	The Coroner's post mortem is conducted in accordance with the *Standards and Recommended Practices for Post Mortem Examination Services* (HSE, 2012)[28] and the *Guidelines for Post Mortem Consent and Retention of Samples* (RCPI/Faculty of Pathology, 2000).[29]	The spouse/partner/next-of-kin of the mother and other relatives access to the deceased mother is facilitated in accordance with the Coroner's instructions.	Staff sensitively explain to the spouse/partner/next-of-kin of the mother and other relatives the reason for any limitations the Coroner may have instructed on viewing the mother's body.	*HSE (2012); Faculty of Pathology RCPI (2000).*
11.1.3	In accordance with direction from the Coroner, staff facilitate supervision of the body in a manner that is sensitive to the family's needs. If forensic examination is ***not*** required and depending on local practice, the Gardaí may or may not supervise transfer of the body to the morgue. In the event that a forensic examination is indicated, the Gardaí will supervise the body until the post mortem is completed.[30]	The lead clinician, senior midwife or bereavement support person accompanies the spouse/partner/next-of-kin of the mother and other relatives to view the deceased.	In accordance with the Coroner's direction, the bereavement support person will stay with the family throughout its time with the deceased.	*HSE (2012).*
11.1.4	The spouse/partner/next-of-kin of the mother and other relatives are advised where and when the post mortem will be performed. In the event that the deceased is transferred to another facility for post mortem, the family are advised that after the examination, arrangements will be made for the release of the deceased to the funeral director in accordance with the family's wishes.	As post mortem facilities are not available in all hospitals, transfer of the deceased to another facility may be required. The family are informed that the hospital will make the necessary arrangements and keep them informed of proceedings.	The spouse/partner/next-of-kin of the mother and other relatives are respectfully informed not to make/finalise funeral arrangements until it is known when the mother's body will be released to the family.	

[28] HSE (2012). *Standards and Recommended Practices for Post Mortem Examination Services*. Available at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/Standards/hsestandardsandguidance/PME_services/PM_services_docs/QPSDD0071.pdf [09 March 2016].

[29] RCPI Faculty of Pathology (2000). *Guidelines for Post Mortem Consent and Retention of Samples*. Available at http://lenus.ie/hse/handle/10147/85172 [09 March 2016].

[30] European Court of Human Rights (2002). *European Convention of Human Rights* (Article 2). Available at http://www.echr.coe.int/Documents/Convention_ENG.pdf [27 May 2016].

	Hospital	Spouse/partner/next-of-kin of the mother, Children, Other Relatives	Key Factors of the Communication Process	Source
11.1.5	In the case where the mother is on a mechanical ventilator and is a patient in an Intensive Care Unit, organ donation may be considered/requested in accordance with the wishes of the deceased mother (if known) or her spouse/partner/next-of-kin of the mother. In the event that a Coroner is investigating a death, the Coroner must consent to the organ donation.	If the mother is a suitable candidate, the intensive care consultant and senior nurse caring for the woman at the time of her death will discuss organ donation with her spouse/partner/next-of-kin of the mother to determine her wishes. **Donor Coordinator can be contacted on: 1890 100 016**	Where agreement to donate has been given, and confirmed in writing, the Organ Transplant Ireland Donor Coordinator is contacted and the relevant care pathways, as laid down by the Office for Organ Donation and Transplant Ireland (ODTI)[31], and the Health Products Regulatory Authority (HPRA)[32], are followed.	*ODTI (2016)[33]; HSE/HPRA (2014) A Framework for Quality and Safety of Human Organs Intended for Transplantation[34].*
11.1.6	A Coroner's investigation may delay the funeral. Staff acknowledge this may cause distress for the spouse/partner/next-of-kin of the mother and other relatives particularly those whose spiritual beliefs require that burial takes place within 24 hours of death. The Clinical Lead advises the family of the restrictions imposed by the coronal investigation, e.g. that there can be no communication of clinical details prior to the Coroner's report.	The spouse/partner/next-of-kin of the mother and other relatives may not have had previous exposure to a Coroner's investigation and therefore may be unaware of the delays the procedure gives rise to.	Relatives are informed that a death certificate will not be available until the Coroner's investigation has been concluded. They are advised that this may take a minimum of 6-12 months. Occasionally it may be possible for the Coroner to issue an interim death certificate (Coroners' Certificate) and the family are given the contact number for the relevant Coroner's office.	*HSE (2012); Dublin District Coroners' Court (http://www.coronerdublincity.ie/faqs/death.htm).*

[31] The Office of the National Organ Donation and Transplant Office (NODTO) was established in 2011 to provide governance, integration and leadership for organ donation and transplantation in Ireland. Available at http://www.hse.ie/eng/about/Who/organdonation/ [26 April 2016].

[32] European Union (Quality and Safety of Human Organs Intended for Transplantation) (Amendment) Regulations, 2014. Available at http://www.irishstatutebook.ie/eli/2014/si/198/made/en/pdf [29 June 2016].

[33] Organ Donation and Transplantation Ireland (ODTI) (2016). *Hospital Information Box Contact Information*. Available on request from Organ Donation Transplant Ireland (ODTI); Contact telephone: 01 8788388. (document reference, ODTI-F-0027 Rev 3).

[34] Organ Donation and Transplantation Ireland (ODTI) (2014). *Quality and Safety Framework for Human Organs intended for Transplantation*. Available at https://www.hse.ie/eng/about/Who/organdonation/publications/ODTI_Quality_and_Safety_Framework_for_Human_Organs_Intended_for_Transplantation.pdf [29 June 2016].

12. Interdisciplinary Communication within and across the Health Services

	Hospital	Rationale for Action	Source
12.1	**The ISBAR communication tool and HSE Open Disclosure Policy are used for all interdisciplinary and interdepartmental communication.** [35]		
12.1.1	The Clinical Risk Manager/Quality & Safety Officer/ Critical Incident Coordinator is notified of the maternal death. He/she is responsible for reporting all early and late maternal deaths to the National Incident Management System (NIMS). The Clinical Risk Manager/Quality & Safety Officer/ Critical Incident Coordinator ensures that the maternal death has been reported to; the Coroner, HSE Acute Hospitals Division, Hospital Group CEO, State Claims Agency (SCA), National Director of Public Health, Director of Public Health Nursing, and Maternal Death Enquiry (MDE) Ireland.[36]	Under the National Treasury Management Agency (Amendment) Act 2000[37] state authorities are obliged to report adverse incidents promptly to the SCA and to facilitate any subsequent investigation. [38] Individual agencies fulfil varying functions and as such will have different reporting requirements.	*HSE (2015); NCEC/HSE (2014); HSE (2014); HSE (2012)*[39].

[35] NCEC/HSE (2014). *Communication (Clinical Handover) in Maternity Services: National Clinical Guideline No 5.* Available at http://health.gov.ie/wp-content/uploads/2015/01/National-Clinical-Guideline-No.-5-Summary-Clinical-Handover-Nov2014.pdf [08 March 2015]. HSE (2013). *Open Disclosure: Communicating with service users and their families following adverse events in healthcare*. Available at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/Open_Disclosure/opendiscFiles/opdiscnationalguidelines2013.pdf [08 March 2016].

[36] MDE report forms available at https://www.ucc.ie/en/mde/ [20 June 2016].

[37] National Treasury Management Agency (Amendment) Act 2000. Available at http://www.irishstatutebook.ie/eli/2000/act/39/enacted/en/html [20 June 2016].

[38] State Claims Agency. *Reporting adverse events*. Available at http://stateclaims.ie/contact-us/reporting-events-or-incidents/ [20 June 2016].
The National Incident Management System (NIMS) is a confidential highly secure web based system. It is an end-to-end risk management tool that allows delegated state authorities (DSA's) to manage incidents throughout the incident lifecycle. This includes: reporting of incidents (including serious reportable events), management of investigations, recording of investigation conclusions, recording of recommendations, tracking recommendations to closure, analysis of incident, investigation and recommendations data and other functionality.

[39] HSE (2012). *HSE Policy for supporting major investigations, receipt of subsequent reports and managing the implementation of the report recommendations*. Available at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/HSEpolicymajorinvestigationsV5.pdf [20 June 2016].

	Hospital	Rationale for Action	Source
12.1.2	All maternal deaths in maternity hospitals/units are subject to an **internal hospital review** as per national policy. The hospital review is conducted in line with the HSE Guidelines for the systems analysis investigation of incidents[40] and local policy.	The purpose of the internal hospital review is to identify any lessons that can be learned from the event and to identify if further investigation is warranted.	*HSE (2014); Saleh et al. (2013); HSE (2012); Garco (2010).*
12.1.3	The internal hospital investigation report will be considered by the hospital Master/Clinical Director/CEO/HM who will decide if the maternal death must be escalated to the next level of management.[41]	A small number of incidents that require direct HSE corporate support are escalated to the HSE Serious Incident Management Team[42] who will directly manage the incident.	*HSE (2014); HSE (2012).*

[40] HSE (2012). *Guideline for Systems Analysis Investigation of Incidents and Complaints*. Available at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/QPSDGL5211.pdf [20 June 2016].

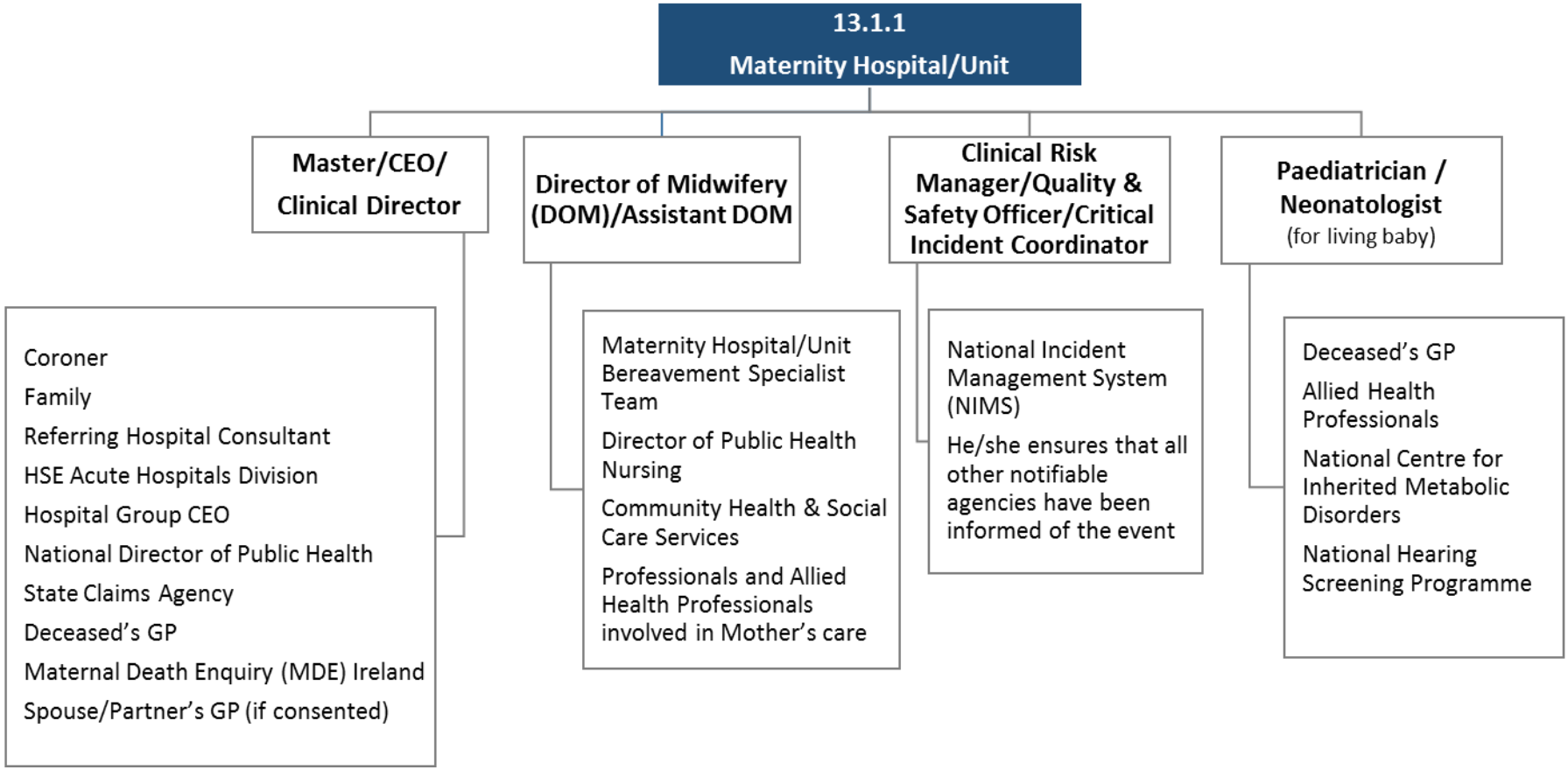
[41] HSE (2012). *HSE Policy for supporting major investigations, receipt of subsequent reports and managing the implementation of the report recommendations*. Available at http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/HSEpolicymajorinvestigationsV5.pdf [20 June 2016].

[42] HSE (2014). *Safety Incident Management Policy*. Available at https://www.hse.ie/eng/about/Who/qualityandpatientsafety/incidentrisk/Riskmanagement/SafetyIncidentMgtPolicy2014.pdf [29 June 2016].

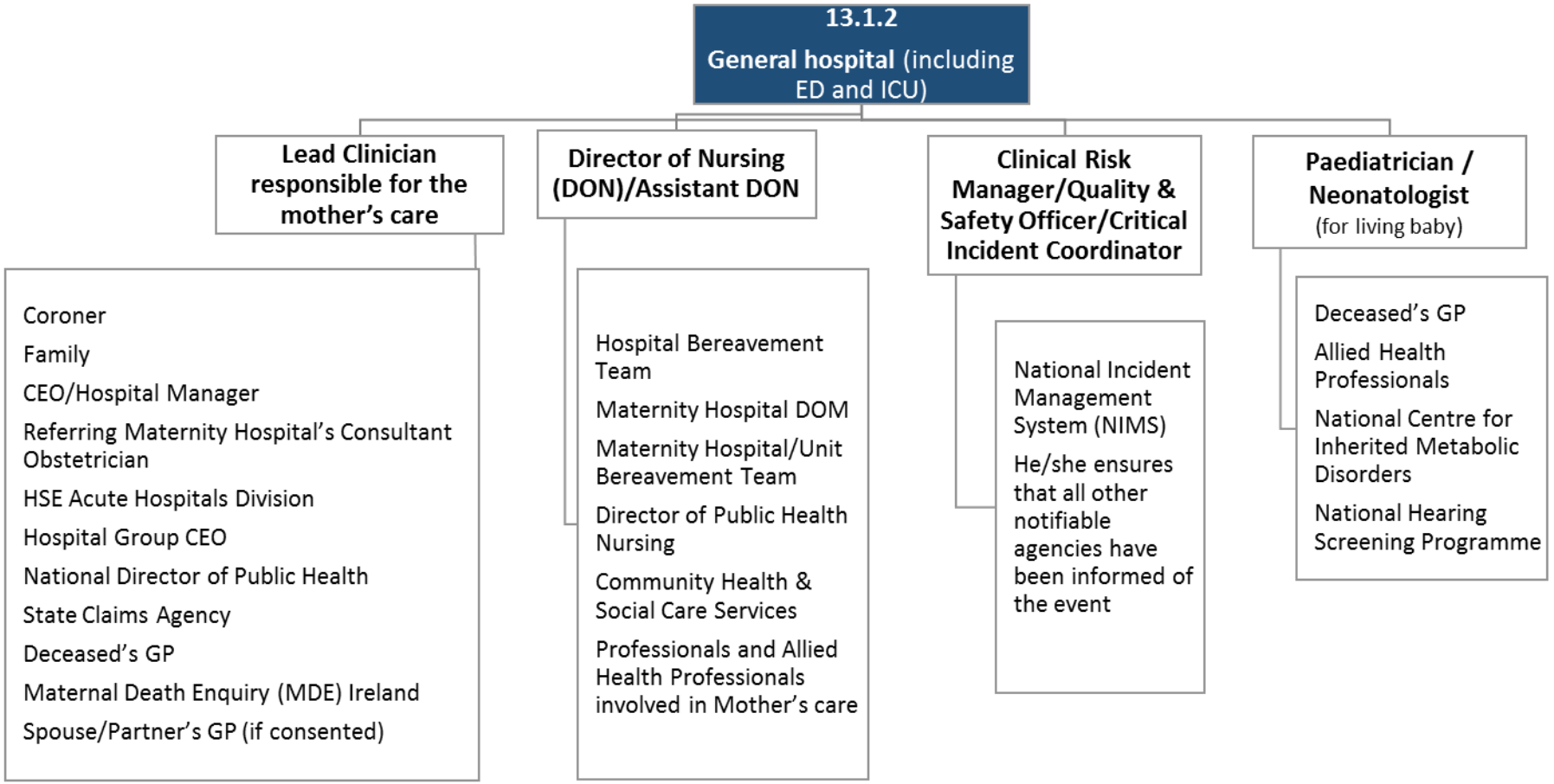
13. Documentation Process

13.1	**Regardless of where the mother is pronounced dead (maternity hospital/unit, general hospital, mental health services, community or specialist palliative care services), notification to relevant parties and services is the responsibility of senior staff where the mother was pronounced dead.**

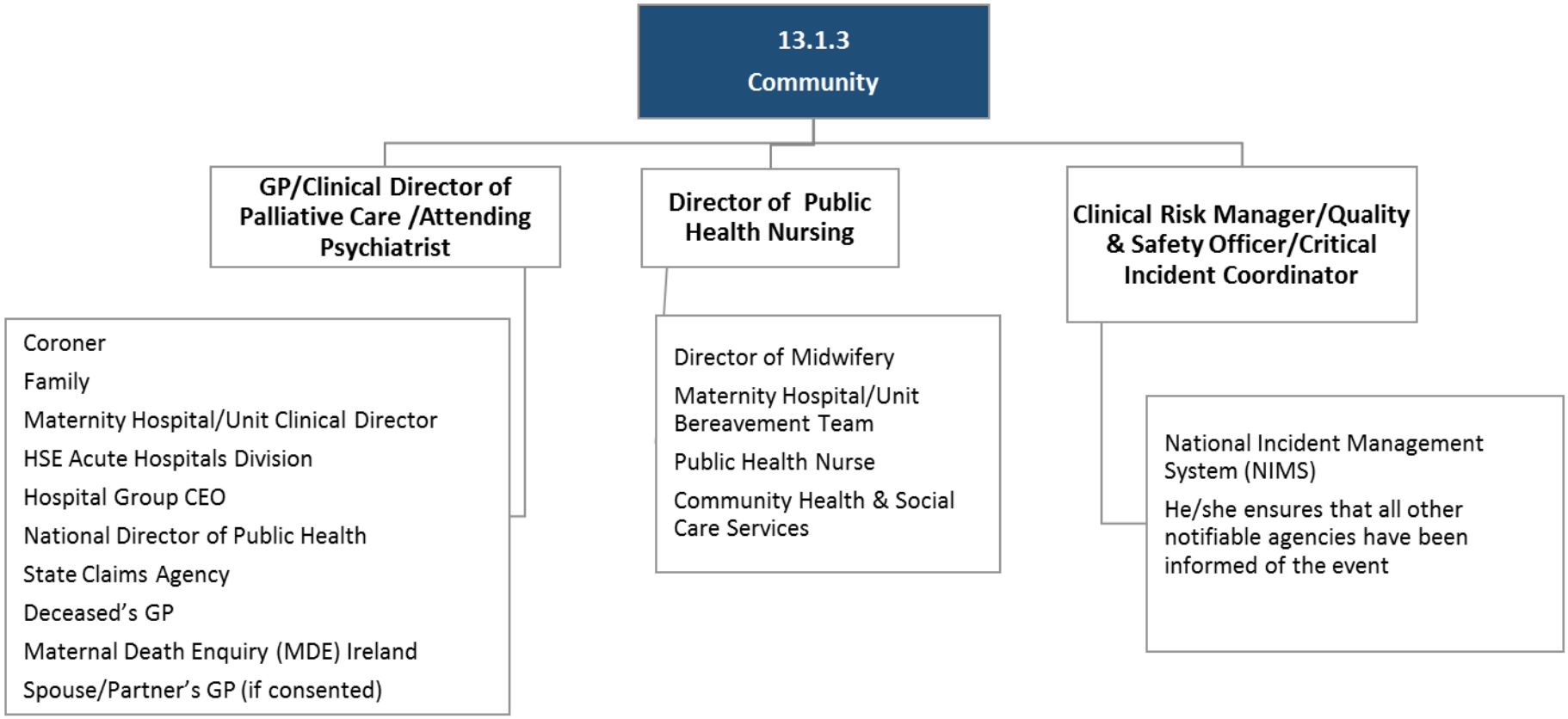
13.1.1 Reporting process following a maternal death in a Maternity Hospital/Unit



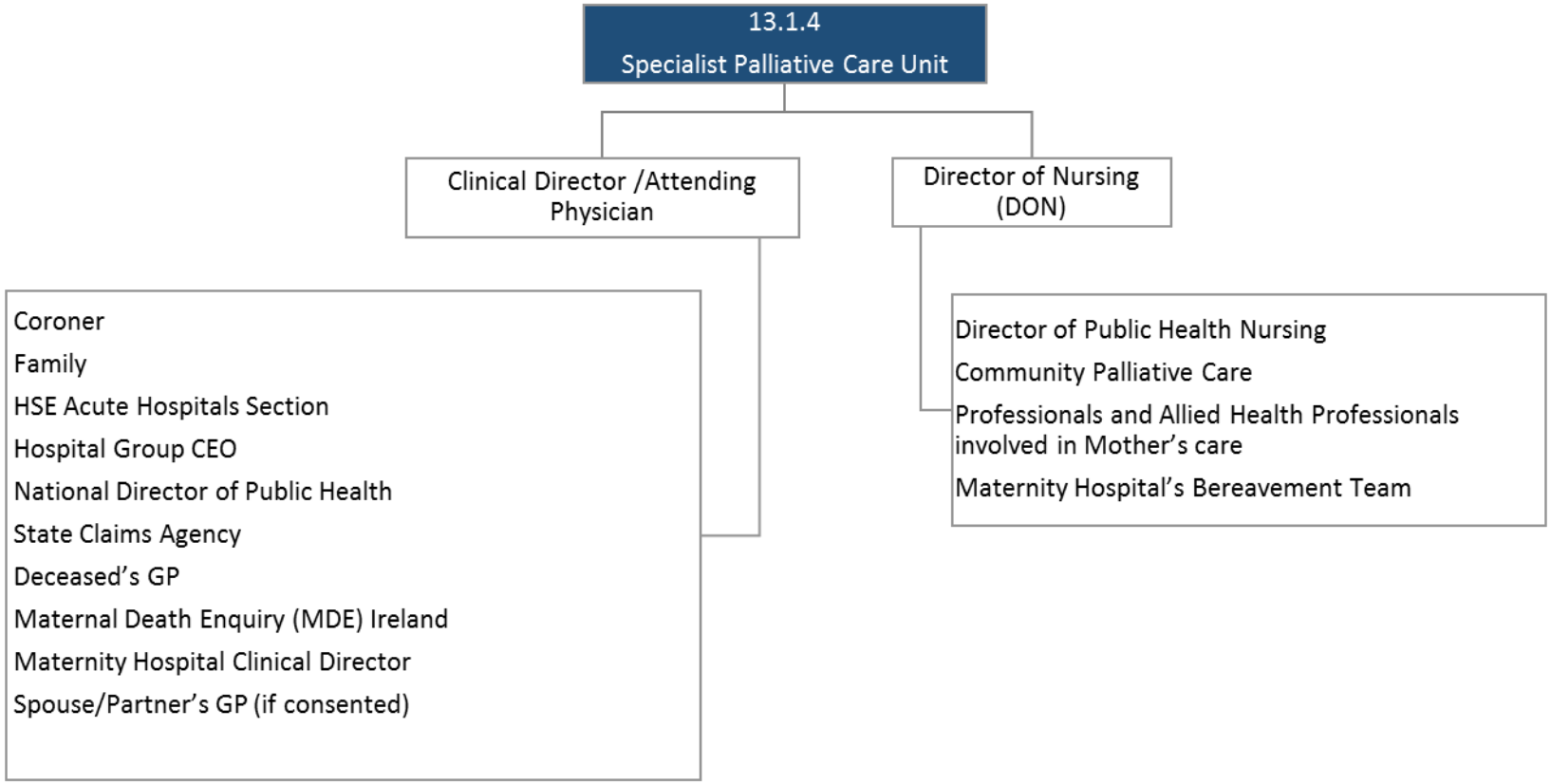
13.1.2 Reporting process following a maternal death in a General Hospital (including ED and ICU)



13.1.3 Reporting process following a maternal death in the Community (e.g. palliative care, mental health services, road traffic accident, the home)



13.1.4 Reporting process following a maternal death in a specialist Palliative Care Unit



	Documentation Process	Source
13.2	The date, time and place of death is verified and recorded by the doctor who pronounced the mother dead.	Civil Registration Act (2004).
13.3	If there is a known cause of death, and if the Coroner is satisfied, a death notification is provided.	Civil Registration Act (2004).
13.4	The staff member responsible for compiling the check list ensures that the designated staff members responsible for notifications (13.1.1 – 13 .1.4) have completed their responsibilities within the best practice time frame, e.g. within 24 hours of the death of the mother.	*Kripalani et al. (2007).*
13.5	The HCR must be completed, clearly documenting all treatment administered, clinical decisions and discussions with spouse/partner/next-of-kin of the mother/family. Each professional is responsible for overseeing the completion of the documents relating to his/her clinical care prior to the HCR leaving the clinical area with the deceased. Senior clinical staff check that all documents are present in the HCR. It may be recommended to photocopy the HCR and for the photocopy to accompany the deceased for post mortem examination. In this instance, the original HCR must be stored confidentially in a secure area, e.g. held by the master/CEO/HM, clinical risk manager/quality & safety officer/ critical incident coordinator or clinical lead and tracked electronically on the Patient Administration System (PAS).	*Hollins Martin & Forrest (2013); Hill (2012).*
13.6	All hospital appointments, including appointments with other and allied professionals are cancelled.	
13.7	The finance department is advised to delay sending bills.	

14. Follow-up Bereavement Support for the Family

Follow-up bereavement support should be timely, easily accessible and should be planned around an anticipation of the needs of individuals. Irrespective of the circumstances of the death, a maternal death for many families, and particularly for children, may be their first encounter with death within the family (Hill, 2012). The family's grief may be compounded by the accompanying death of a baby who will have been a daughter/son, sibling, grandchild, niece/nephew and in some instances a great grandchild. There is no time limit on when the bereaved person can adjust to his/her new reality. Supportive dialogues after a death have been found to strengthen family members (Lundberg et al., 2013). It is recognised that the completion of the first year of widowhood that might be expected to herald a lessening of grieving is instead for many, the time when the greatest and most difficult problems begin (Picano, 1997).

	Hospital Role in Follow-up Bereavement Support	Source
14.1	Hospital Management is responsible for ensuring that follow-up bereavement care is provided for the family. Follow-up bereavement support should be timely, easily accessible and should be planned around the anticipated or expressed needs of spouses/partners and other family members.	*Lundberg et al (2013); Corden & Hirst (2013); Walter (2003).*
14.2	Offers of bereavement support should be proactive and assessment of spouse/partner/next-of-kin of the mother, children and other relatives' needs should be considered. Referral to auxiliary support services, e.g. social care is considered.	*NICE (2013); Hill (2012).*
14.3	Staff acknowledge that, in the interest of providing effective bereavement support, it is necessary to identify who is most vulnerable. The risk of ill health is greatest among persons who have complex situational, intrapersonal, interpersonal circumstances and poor coping factors.	*Stroebe & Schut (2016); Lai et al. (2014); Walter (2003).*
14.4	If the spouse/partner/next-of-kin of the mother and/or nominated relative has agreed, a follow-up telephone call is made within one week of the mother's death by either the bereavement coordinator or the nominated bereavement support person who accompanied the family while in hospital. Where it has not been possible to establish contact by telephone, a letter is sent to the spouse/partner/next-of-kin of the mother/nominated relative.	*Lundberg et al. (2013); Fraser & Atkins (1990).*
14.5	Follow-up bereavement support is sensitively explained. The spouse/partner/next-of-kin of the mother, children and other relatives are invited to avail of the service at a time of their choosing and they are provided with contact details for the bereavement coordinator and/or bereavement support person who will organise the follow-up bereavement care.	*Hospice UK (2015); NICE (2013).*

	Hospital Role in Follow-up Bereavement Support	Source
14.6	Irrespective of where the maternal death takes place, the BST in the hospital where the mother registered for maternity care is available to provide follow-up bereavement support. If applicable, and with the consent of the family, the BST will notify the bereavement coordinator/team in the maternity hospital/unit of the death, and of the family's wish to avail, or not avail, of follow-up bereavement support in the maternity hospital/unit.	*HSE (2014).*
14.7	In the event that there is no bereavement service in the hospital where the mother died, and if the family do not wish to avail of bereavement support in another hospital, the family are provided with verbal and written information on where bereavement support for adults and children can be sourced close to their home. Family members are advised to visit their GP for referral to the local community services.	*HSE (2014).*
14.8	Written information on support groups for adults and children is provided to the family. The BST links with the family's Primary Health Care Team (PHCT) and provides written and verbal information on local bereavement support.	
14.9	During follow-up bereavement support, the spouse/partner/next-of-kin of the mother and other relatives are offered assessment of their practical needs including where necessary, immediate and/or long-term child care needs, by the medical social worker on the BST.	
14.10	If not already provided and where available, the collected keepsakes/mementoes of the deceased mother and baby are offered to the family during a follow-up appointment.	*Roose & Blanford (2011); Capitulo (2005); Busch & Kimble (2001).*
14.11	The spouse/partner/next-of-kin of the mother and other relatives are informed that the deceased Mother's GP, PHN and all other social and health care professionals and allied professionals whom she attended have been informed of her death.	*Kripalani (2007); Hummel & Cronin (2004).*

15. Staff Support following a Maternal Death

A maternal death will, for most staff, be an event well outside the sphere of usual human experience (Ellis et al., 2016; Huggard, 2011; McCool et al., 2009) and has been described as an experience comparable with that of emergency personnel attending large scale disasters (Mander, 2001). Hospital Management is responsible for providing formal structures to support staff following an adverse event in the maternity and perinatal services, and to provide this service for the duration recommended by the support service. Hospital Management puts in place a support system that is cognisant of the importance of staff support, and particularly for those members who do not have a strong natural social network.

	Staff support following a maternal death	Source
15.1	It is the responsibility of senior management to organise formal debriefing for staff who provided care to the mother and her family. Debriefing is; • facilitated by an appropriate discipline, e.g. clinical psychologist/clinical supervisor accessed within the HSE • offered to all grades and disciplines of staff • facilitated in a timely fashion (within days of the event) Staff are offered contact details for the employee assistance programme should they need further support following debriefing. Management ensures that all staff are trained to recognise the symptoms of post-traumatic stress disorder (PTSD) and receive training on how to respond to symptoms of PTSD.	*Larcher et al. (2015); Nuzum (2014); NICE (2013); (HSE, 2013)[43]; Hill (2012); Wenzel et al. (2011); Huggard (2011); Genevra & Miller (2010); Keene et al. (2010); Houghton & Christensen (2006).*
15.2	It is acknowledged that staff benefit from participating in peer support. Management is cognisant of the importance of facilitating peer support.	*Wenzel et al., (2011); Houghton et al. (2006).*
15.3	Remembrance services that include perinatal deaths, pregnancy loss and maternal deaths are held annually for families and staff.	*ISANDS (2007); SANDS (3rd ed., 2007).*

[43] HSE (2013). Supporting staff following an adverse event: the 'assist me' model. Available at http://lenus.ie/hse/handle/10147/305964 [20 June 2016].

16. Sample checklist for person coordinating events following a maternal death

Have you documented the following?

Deceased's name:

Date of birth:

Date and time of death:

Address:

Spouse/partner/next-of-kin:

Relationship of spouse/partner/next-of-kin to the deceased:

Address of spouse/partner/next-of-kin:

Telephone contact for spouse/partner/next-of-kin:

Additional relative's name and contact telephone number:

Relationship of additional relative to the deceased:

Name of Incident Coordinator (block capitals):

Signature of Incident Coordinator _____

Activity	**Yes (√)**	**Date & Time**	**Completed by (block capitals)**	**Initials**
At time of death ensure that the following are notified:				
Coroner Local Coroner's office telephone number:				
Next-of-kin of the mother (if not present)				
Interpreter (if required)				
Lead Clinician (caring for the mother at the time of her death)				

Activity	Yes (√)	Date & Time	Completed by (block capitals)	Initials
Master/ Clinical Lead/CEO/Hospital Manager				
Director of Midwifery/Nursing				
Director of Anaesthesiology				
Clinical Director				
Nurse/Midwife in charge of Unit where the mother died				
Clinical Director of Paediatrics (if appropriate)				
Clinical Nurse Manager (CNM) in charge of Neonatal Unit (if appropriate)				
Bereavement Coordinator/Midwife/Nurse specialist in bereavement and loss				
Chaplain				
Gardaí (if applicable)				
Pathologist				
Mortuary Attendants/Pathology Technicians				
Clinical Risk Manager/Quality & Safety Manager/ Critical Incident Coordinator				
Referring hospital (if applicable)				
Medical Social Worker (if applicable)				
Communications:				
Ensure that reception and switchboard staff are informed of death and are instructed on whom to contact regarding enquiries, e.g. DON/DOM.				

Activity	Yes (√)	Date & Time	Completed by (block capitals)	Initials
Inform the deceased's GP and if appropriate the spouse/partner/next-of-kin of the mother's GP				
Inform the National Director of Public Health				
Inform the Director of Public Health Nursing				
Inform the Hospital Psychiatrist (if applicable)				
Inform the Obstetric Clinical Lead in the maternity hospital/unit where the deceased was receiving care				
Inform the Bereavement Specialist Team in the maternity hospital/unit where the deceased was receiving care				
Inform Social Services (if applicable)				
Inform Mental Health Services (if applicable)				
Contact allied health professionals, e.g. physiotherapist, mental health nurse (if applicable)				
Inform the National Centre for Inherited Metabolic Disorders (if baby alive)				
Inform the National Hearing Screening Programme (if baby alive)				
Consent				
Consent for hospital post mortem.				
Coroner's information form completed if Coroner's post mortem authorised[44]				

[44] Where a Coroner's post mortem is authorised, the NOK of the mother is given details of what the examination entails and this is documented in a Coroner's information form. The NOK of the mother confirms that he/she has been given verbal and written information regarding the examination. Where the NOK of the mother declines information this should also be documented. A copy of the information form should be offered to the NOK of the mother.

Activity	Yes (√)	Date & Time	Completed by (block capitals)	Initials
Consent for treatment for baby (if applicable)				
If applicable, location of mementoes awaiting collection If applicable, name of spouse/partner/next-of-kin of the mother or family member to whom the mementoes were given.				
Forms				
Notification of Death form				
Birth or Stillbirth Certificate (as appropriate)				
Completed MDE Ireland Maternal Death Notification Form[45]				
Critical Incident Report				
Documentation Accurate documentation in all cases of maternal death is essential				
Check that all clinical reports are inserted in HCR in preparation for formal clinical follow up				
HCR completed by individuals who were clinically involved				
HCR accompanied the deceased for Pathologist's reference.				
Photocopy of the HCR accompanied the deceased for Pathologist's reference				

[45] Available at; https://www.ucc.ie/en/media/research/maternaldeathenquiryireland/MDEMaternalDeathNotificationForm2.pdf

Activity	Yes (√)	Date & Time	Completed by (block capitals)	Initials
In the event that the original HCR did not accompany the deceased, has it been sent to the master/CEO/hospital manager/clinical risk manager/quality & safety manager/ critical incident coordinator or other? Location of chart (Block Capitals): _____ **Chart is tracked electronically on the Patient Administration System (PAS).**				
Follow-Up Debriefing is recommended for relatives and all staff involved in a maternal death				
Follow-up appointment for spouse/partner/next-of-kin of the mother with a member of the BST				
Follow-up appointment with Paediatrician (if applicable)				
Identified member of staff to act as contact and bereavement support person for the family _____				
Follow-up group debriefing organised for staff, and Staff notified of date, time and location of debriefing exercise by _____ (signature of staff member)				

17. Roles and Responsibilities of Multidisciplinary Team: Hospital-based Members

Bereavement Coordinator

The bereavement coordinator's role in hospitals is central to the bereavement service and he/she is the point of contact for all bereaved spouses/partners and families in the immediate aftermath of the mother's death, after they have left the hospital, and down the line. In the event that a family should choose to be referred for bereavement care, the bereavement coordinator will establish contact with the bereavement coordinator in the unit/hospital where the mother received maternity care or, in his/her absence, clinical midwife specialist (CMS) in bereavement in the specified maternity unit/hospital.

The Bereavement Coordinator is responsible for the development, implementation and evaluation of the hospital's bereavement programme. He/she works closely with the CMS in bereavement, Chair of the Bereavement Committee, CMS in bereavement, MSW, Chaplain and associated professionals and hospital management. He/she is responsible for ensuring the hospital has capacity and referral systems in place for providing each of the levels of bereavement care. The Bereavement Coordinator has overall responsibility for the educating, training and upskilling all hospital staff in bereavement care.

Bereavement Committee

The bereavement committee is multidisciplinary and composed of; a senior hospital administrator, clinical midwife/nurse specialist in bereavement, bereavement coordinator, medical social worker with responsibility for bereavement care, chaplain, clinical leads, director of midwifery/nursing, and service users. The committee also includes a nominated midwife/nurse manager, an anaesthetist, a sonographer, and a representative from pathology, laboratory, mortuary, clerical and household staff. The committee convenes on a regular basis as determined locally.

Bereavement Specialist Team (BST)

The BST is composed of staff members who have undertaken specialist and extensive education in bereavement care. The team includes; a bereavement coordinator, clinical nurse/midwife specialist in bereavement, chaplain and senior medical social worker. The team is supported in its work by the master/hospital CEO/HM, director of nursing/midwifery, clinical leads, paediatricians, anaesthetists, psychiatrists, nurses, midwives, neonatal care nurses, ministers of religions, palliative care teams, bereavement committee, end-of-life care committee, administrative and auxiliary staff – all of whom have received training appropriate to their role in bereavement care (Bates et al. for the HSE, 2008).

Bereavement support person caring for the mother and her family at the time of her death

The nominated bereavement support person is the most experienced midwife or nurse involved in the care of the mother at the time of her death (HSE, 2013). He/she is freed from other clinical duties for the duration of the relatives' stay in hospital so that he/she can be available to them at all times.

Chaplain

The role of the healthcare chaplain is to provide spiritual and pastoral support to mothers, bereaved partners/spouses and their families in the midst of illness or bereavement. This support is available to all and respects the personal, spiritual, religious and cultural expressions (or none) of the individual and other relatives, and is provided in accordance with the Association for Clinical Pastoral Education (ACPE) training and in accordance with Healthcare Chaplaincy Board (HCB) and/or Chaplaincy Accreditation Board (CAB) requirements.

Clinical Lead caring for the Mother at the time of her death

The term is used in this guideline to identify the doctor responsible for decision making and care during the various stages of the woman's critical illness and at the time of her death. The clinical lead may be an intensivist (critical care physician with special training and experience in treating critically ill patients); an emergency physician; an anaesthetist; an obstetrician; palliative care doctor or a psychiatrist. The clinical lead caring for the mother at the time of her death is responsible for contacting the Coroner, the clinical risk manager/quality & safety manager/critical incident coordinator, the clinical director, the master/chief executive officer/hospital manager, the director of nursing/midwifery, the BST, and all agencies as identified in 13.1.1 – 13.1.4. He/she is required to participate in an internal hospital investigation and to attend the Coroner's Court if an inquest is held. In the event that the mother's obstetrician is not present at the time of her death, the clinical lead caring for the mother at the time of her death establishes contact with him/her.

Clinical Lead for follow-up care and investigations

The Clinical Lead for follow-up care and investigations has a significant involvement in, and responsibility for, bereavement care following the death of a mother. He/she works closely with the multidisciplinary team (anaesthetists, paediatricians, senior nurses/ midwives, the BST and the nominated bereavement support person directly involved in the case). Clinical leads are appointed in all hospitals. The responsibilities of the Clinical Lead for follow-up care and investigations include:

- ensuring that the Coroner has been notified and that the appropriate clinical information has been given to the Coroner
- advising the family of the general restriction, imposed by the coronal investigation, on the amount of information that can be communicated to the family
- notifying or ensuring the notification of the appropriate statutory bodies and associated agencies (HSE, SCA, MDE)

- conducting or participating in both local and statutory investigations
- ensuring that the appropriate bereavement support services have been put into place for relatives
- the lead clinician will provide updated information, address concerns, and ensure appropriate ongoing support for the spouse/partner/next-of-kin of the mother and other relatives (HSE, 2014)
- attend the Coroner's Court, if inquest is required
- ensure, in conjunction with other senior colleagues and management, that staff involved directly in the case, and staff indirectly involved, e.g. reception staff, are given appropriate debriefing and support

After due consideration, and in the context of the conclusions of the investigations undertaken, and having discussed with senior clinical staff and hospital management, the clinical lead has the authority and responsibility to openly disclose any deficiencies in care that may have contributed to the death and to apologise for this. He/she apologises for any errors that might have occurred and demonstrates what actions have been taken to minimise the risk of any such errors occurring again.

Clinical Midwife Specialist/Clinical Nurse Specialist (CMS/CNS) in Bereavement

The CNS/CMS in bereavement is an experienced nurse/midwife who has undertaken specific training and education at Level 8 or above in the area of bereavement. There are five core concepts that define the role of the CNS/CMS in bereavement; clinical focus, patient/client advocacy, education and training, audit and research. The CNS/CMS's main focus of care is the direct provision of bereavement counselling support to bereaved spouse/partner/next-of-kin of the mother, siblings and family members (HSE, 2014). The CNS/CMS in bereavement provides anticipatory bereavement counselling support to families when a maternal death is anticipated and works closely with the MDT within the framework of the palliative model of care. In the event that a bereaved spouse/partner/next-of-kin of the mother wishes to be referred to the maternity hospital/unit for follow-up bereavement care, the CNS in bereavement in the hospital where the mother died will, with the consent of the bereaved spouse/partner/next-of-kin of the mother, provide relevant information to the CMS in bereavement in the maternity unit/hospital.

Clinical Nurse Manager (CNM)/Clinical Midwife Manager (CMM)

The CNM/CMM ensures the spouse/partner/next-of-kin of the mother, children and other relatives are cared for in an appropriate private area where their immediate needs are attended to. He/she makes sure that the family are provided with timely sensitive communication by a senior clinician; that consideration is given to the needs of the infant, be he/she alive or stillborn, and that visitors are facilitated. It is the responsibility of the CNM/CMM to ensure that staff are aware of hospital guidelines and policies; clinical procedures; reporting mechanisms and the role of the Coroner. The CNM/CMM must communicate with the MDT, the clinical risk manager/quality & safety

manager/ critical incident coordinator, director of public health nursing and the community medical and social care services.

Coroner

The Coroner's core function is to investigate sudden and unexplained deaths so that a death certificate can be issued. This is an important public service to the living and in particular for the next-of-kin of the mother and relatives of the deceased. The Coroner Service not only provides closure for those bereaved suddenly but also performs a wider public service by identifying matters of public interest that can have life/death consequences. Coroners appreciate that the procedures involved in their inquiries, though necessary, may involve upset and trauma for the spouse/partner/next-of-kin of the mother, family and friends. Coroners will carry out their work as sensitively as possible and with respect for the deceased, spouse/partner/next-of-kin of the mother, family and friends.[46]

Clinical Risk Manager / Quality & Safety Officer / Critical Incident Coordinator

A clinical incident such as a maternal death is a serious reportable event (SRE). It is a mandatory requirement of the HSE that all maternal deaths are reported on the National Incident Management System (NIMS) of the State Claims Agency (SCA) within 24 hours.[47] The clinical risk manager/quality safety officer/critical incident coordinator ensures that the maternal death is reported to all notifiable agencies (see 13.1.1 - 13.1.3).

Director of Midwifery (DOM)/ Nursing (DON)

The Director of Midwifery (DOM)/ Nursing (DON) is responsible for ensuring that, in the event of a maternal death in the hospital, policy, standards and processes are in place to support the spouse/partner/next-of-kin of the mother, children, other relatives and staff (HSE, 2014) . He/she has overall responsibility for ensuring that policies and procedures are adhered to and implemented in relation to care of bereaved families. He/she works closely with the Master/CEO/HM to ensure best practice is maintained in the provision of care to the family. He/she oversees and supports the bereavement team caring for the family during what is generally an extremely rare, but most stressful, event ever encountered in hospitals. He/she ensures that relevant agencies have been informed of the maternal death (see 13.1.1- 13.1.4).

[46] http://www.coroners.ie/en/CS/Pages/Overview [08 March 2016].

[47]The National Incident Management System (NIMS) is a confidential highly secure web based system. It is an end-to-end risk management tool that allows delegated State authorities (DSA's) to manage incidents throughout the incident lifecycle. This includes: reporting of incidents (including serious reportable events), management of investigations, recording of investigation conclusions, recording of recommendations, tracking recommendations to closure, analysis of incident, investigation and recommendations data and other functionality. http://stateclaims.ie/contact-us/reporting-events-or-incidents/ [07 March 2016].

Master/Chief Executive Officer/Hospital Manager (CEO/HM)

The Master/CEO/HM has ultimate responsibility for implementing and auditing hospital bereavement services. Bereavement services form an integral part of what the hospital provides to its patients and their families. This is achieved through ensuring that bereavement resources and services are in place to assist patients who may require them. The CEO/HM ensures that procedures are in place to support best practice in bereavement care, delegating authority to ensure that all practical and organisational issues are addressed such as provision of prompt assistance with regard to any formal paperwork that may be required (HSE, 2013; HSE, 2013). His/her responsibilities include ensuring that policies are in place for the efficient processing of practical tasks and that these are regularly reviewed and updated (e.g. liaising with funeral undertakers and liaison with the relevant statutory authorities) so that these may be dealt with in a prompt and sympathetic manner. He/she ensures that literature appropriate for bereaved spouses/partners, children and other relatives is available and provided. The Master/CEO/HM acknowledges the impact of a maternal death on staff and puts in place the resources necessary to debrief and support staff (HSE, 2013).

Medical Social Worker (MSW)

The Medical Social Worker (MSW) provides emotional and practical support at a time of maternal death to bereaved spouses/partners, children and other relatives. He/she is available to offer bereavement support in the weeks and months following death. The MSW also provides advice on children and loss and is available to do direct work with children, if this support is needed. He/she is an advocate for bereaved spouses/partners and families and works as part of the BST to ensure optimum care for bereaved families.

Paediatrician/Neonatologist

The clinical lead in paediatrics/neonatology determines who is the baby's parent/guardian and provides the immediate care for the baby. He/she is responsible for providing the new born examination and arranges for the new born screening tests, e.g. for metabolic disorders, hearing. He/she makes arrangements for appropriate care and follow-up for the baby and provides the spouse/partner/next-of-kin of the mother/guardian with regular updates on the baby's well-being.

Pathologist

The role of the pathologist in a coronal investigation differs from that of the pathologist conducting a hospital post mortem. The Coroner is responsible for appointing the pathologist to conduct a post mortem for a coronal investigation. Hospital (consented) post mortems are performed by the hospital's pathologist.

Pathologists ensure that coronal post-mortems are performed to a high standard and in keeping with national and international guidelines. They are responsible for integrating information obtained from the post-mortem examination and other available investigations to formulate a cause of death (if possible) and to correlate the pathological findings identified with the clinical course leading up to the maternal death. If a definitive cause of

death is not identified, potential contributors or relevant negative findings can be documented. Information obtained at a coronal post mortem is not necessarily made available to the medical team prior to the Coroner's report and inquest.

Hospital (consented) post mortems are performed by the hospital pathologist who may communicate the results of his/her post-mortem to the clinical lead. The monthly clinical meeting at which cases are reviewed is an important forum for this communication as it ensures accurate understanding of all aspects of individual cases and thereby facilitates appropriate follow-up. These discussions are also a valuable forum for learning for doctors, midwives, the BST and students within the hospital. The pathologist performs and facilitates research into maternal death so that rates of maternal mortality can be reduced. The hospital pathologist ensures that members of the BST and other staff, as appropriate within the hospital, are educated about the post-mortem process, what it involves and what it is possible to do.

18. Implementation of Guideline

An implementation group has been set up to identify the resources required, and the processes necessary, for the successful implementation in all hospitals of the *National Guideline for Bereavement Care following Maternal Death within a Hospital Setting* and the *Standards for Bereavement Care following Pregnancy Loss and Perinatal Death*. The group is tasked with;

- the dissemination of the guideline to all hospital and community health service providers
- the development of teaching methodologies and teaching aids
- train the trainer workshops
- the design and dissemination of national literature covering maternal death, pregnancy loss, perinatal death and congenital fetal anomaly
- the development of audit tools including a confidential service user feedback process
- the development of debriefing programmes for hospital employees (HSE, 2013)
- site visits
- bereavement care summit

19. Audit and Revision of Bereavement Care Guideline

The bereavement service will be audited through the tools under development by the Implementation Group. The audits, in conjunction with documented findings from the multidisciplinary perinatal and maternity morbidity and mortality meetings, and confidential service user feedback, will be used to measure the quality of the bereavement service. Multidisciplinary bereavement care pathways will be reviewed and revised as indicated through the audits, and in keeping with national clinical guidelines, and up-to-date research based best clinical practice.

Appendix 1. National Legislation

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Appendix 5. Abbreviations

BST	Bereavement Specialist Team
CEO	Chief Executive Officer
CEMACH	Confidential Enquiries in Maternal and Child Health, UK
CEMD	Confidential Enquiry in Maternal Death, UK
CMM	Clinical Midwife Manager
CMS	Clinical Midwife Specialist
CNM	Clinical Nurse Manager
CNS	Clinical Nurse Specialist
CPM	Coroner's Post Mortem
CRS	Civil Registration Service
DOM	Director of Midwifery
DON	Director of Nursing
ED	Emergency Department
GP	General Practitioner
HCR	Health Care Record
HIQA	Health Information and Quality Authority
HM	Hospital Manager
HSE	Health Service Executive
ICD	International Classification of Diseases
ICU	Intensive Care Unit
ID	Identity
IHF	Irish Hospice Foundation
IMO	Irish Medical Organisation
MBBRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MDE	Maternal Death Enquiry, Ireland
MDT	Multidisciplinary Team
MMR	Maternal Mortality Rate
MSW	Medical Social Worker
NHS	National Health Service (UK)
NIMS	National Incident Management System
NICE	National Institute for Clinical Excellence (UK)
NMBI	Nursing and Midwifery Board of Ireland (An Bord Altranáis)

NPEC	National Perinatal Epidemiology Centre
ONS	Office for National Statistics
PAS	Patient Administration System
PHN	Public Health Nurse
RCOG	Royal College of Obstetricians and Gynaecologists (UK)
RCPI	Royal College of Physicians in Ireland
RCSI	Royal College of Surgeons in Ireland
SCA	State Claims Agency
UCC	University College Cork
UCD	University College Dublin
WHO	World Health Organisation

Appendix 6. Resources for Families Following Maternal Death

- Short-term child care: facilitated by Hospital MSW
- Long-term child care: facilitated by Community MSW. Contactable through Community Welfare Services. https://www.hse.ie/eng/services/list/1/schemes/cwo/Community_Welfare_Services_.html [16 October 2016].
- Family Support Worker (TUSLA - Child and Family Agency) http://www.tusla.ie/services/family-community-support/family-support [16 October 2016].
- Home Help Assistance: coordinated by local Public Health Nursing Services.
- Citizens Advice Board http://www.citizensinformationboard.ie/ [16 October 2016].
- Citizens Information Centres www.citizensinformation.ie [16 October 2016].
- Department of Social Protection https://www.welfare.ie/en/Pages/home.aspx. [16 October 2016].
- Money Advice Bureau (MABS) contact details
  Telephone: 0761 072000
  https://www.mabs.ie/ [16 October 2016].

Support Groups

Association	Services	Contact
Anam Cara	• support for parents and siblings following the death of a child • provide information • on-line forums for parents, siblings and volunteers • support group meetings • guest speakers • counselling	HCL House, Second Avenue, Cookstown Industrial Estate, Tallaght, Dublin 24 http://www.anamcara.ie/ Telephone: 01 404 5378 Email: info@anamcara.ie
Aware	• provide information, education and support to people with mental health problems and to their families • provide support through meetings, by email and telephone • offer interactive talks and workshops in schools and workplaces	Telephone: 01 661 7211 Freephone: 1800 80 48 48 Service available 10am-10pm Monday-Sunday https://www.aware.ie/contact/

Association	Services	Contact
Bethany Bereavement Support	• voluntary support groups located in most counties and organised within parishes Many Bethany members have themselves been bereaved and are trained to listen with understanding	www.bethany.ie See website for local contacts
Barnardos	• provide national bereavement counselling service specifically for children • provide information and advice through its helpline and counselling for bereaved children	Dublin Christchurch Square Dublin 8 Tel: 01 453 0355 http://www.barnardos.ie/what-we-do/our-services/specialist-services/bereavement-counselling.html
Compassionate Friends Ireland	• non-profit charitable organisation established in 2008 to provide consolation and support during the grieving process to families in which a child dies.	http://www.compassionatefriendsireland.ie/ Email: compassionatefriendsireland@gmail.com Telephone: Mary 086 382 2624. Nick 087 254 0355
Crosscare Teen Counselling	• provide counselling service for 12 – 18 year olds • offer bereavement counselling to young people and their families	Crosscare, The Red House, Clonliffe Road, Dublin 3 Telephone: 01 836 0011 www.crosscare.ie/teencounselling Email: info@crosscare.ie
Irish Childhood Bereavement Network	• founded in 2012 to act as a hub for those working with bereaved children, young people and their families. • provide information about age appropriate literature for children	Telephone: 01 679 3188 http://www.childhoodbereavement.ie/
Irish Hospice Foundation	• a national charity dedicated to all matters relating to dying, death and bereavement in Ireland	Telephone: 01 679 3188 www.hospicefoundation.ie
Irish Patients Association	• advocate for the needs of patients while working in partnership with health care providers • provide information to various committees, working groups and public bodies on behalf of patients.	Tel: 087 6594183 http://irishpatients.ie/
National Office for Suicide Prevention	The National Office for Suicide Prevention (NOSP) supports implementation of Ireland's suicide prevention strategy.	Telephone: 1850 24 1850 http://www.hse.ie/eng/services/list/4/Mental_Health_Services/NOSP

Association	Services	Contact
Patients for Patients Safety (PFPSI)	Patients for Patients Safety Ireland (PFPSI), is a World Health Organisation (WHO) initiative aimed at improving safety in healthcare. PFPSI is supported by the HSE Quality Improvement Division. The WHO believes that safety will only be improved if patients are placed at the centre of care and included as full partners. This initiative brings together patients, providers, policy-makers and those affected by harm who are dedicated to improving health care safety through advocacy, collaboration and partnership. Members speak at patient safety events, work with health care teams to promote and encourage improvements in patient safety, and highlight areas of unsafe practice focused by their own experiences.	http://www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/patientsafety/
Pieta House	• offer support to people bereaved by suicide • operate the Suicide Bereavement Liaison Service and the Suicide Bereavement Counselling Service (previously operated by Console	To locate a Pieta House service in your locality: Telephone: 1800 247 247 **or access information at:** http://www.pieta.ie/ive-been-bereaved-by-suicide/
TUSLA (Child and Family Agency)	• child protection and welfare services • education welfare services • psychological services • alternative care • family and locally-based community supports • early years services • domestic, sexual and gender-based violence services	St. Stephens Green House, Earlsfort Terrace, Dublin 2. Telephone: (01) 611 4100 Email: info@fsa.ie www.fsa.ie

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