

Maternal Mortality Investigation
Case Review Summary Report

INITIAL DIAGNOSIS

Date of Case Review: *DD/MM/YYYY*

Patient's Demographics

Patient Name: _____ Medical Record Number: _____
Date of Birth: *DD/MM/YYYY* Age: _____

Death Summary

Date of death: *DD/MM/YYYY* Time of death: *HH:MM* am pm
Date of delivery/termination: *DD/MM/YYYY* Days to death: _____ days
Place of delivery/termination: _____
Gravida: _____ Parity: _____

Place of death (for hospital deaths)

<input type="radio"/> Antenatal ward	<input type="radio"/> Accident & Emergency	<input type="radio"/> ICU / HDU
<input type="radio"/> Labour ward	<input type="radio"/> Operating theatre	<input type="radio"/> Postnatal ward
<input type="radio"/> Non-obstetrics ward	Non-obstetrics ward: _____	

Classification of Death

<input type="radio"/> Direct	<input type="radio"/> Coincidental
<input type="radio"/> Indirect	<input type="radio"/> Indeterminate

Timing of Death

<input type="radio"/> Maternal death	<input type="radio"/> Late maternal death
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Type of Death

<input type="radio"/> Avoidable	<input type="radio"/> Unavoidable	<input type="radio"/> Unknown
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Cause of Death:

Cause	Details
i. (a) Immediate	
(b) Intermediate	
(c) Intermediate	
(d) Underlying	
ii. Other significant conditions	

Three Delay Model

Were any delays identified? Yes No Unknown

Which delay(s) were identified?

1- Delay in seeking care 2- Delay in accessing care 3- Delay in receiving care

Name of Patient:

Medical Record Number:

DELAY 1 - Delay in seeking care

Delay Category	Delay Type	Present		
Delay in seeking care	Patient did not recognize problem	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Patient delayed seeking care	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Previous poor experience with health care	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Other	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown

Specify details of the delay 1:

DELAY 2 - Delay in accessing care

Delay Category	Delay Type	Present		
Delay in accessing care	Delayed access due to cost	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Delayed access due to transportation	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Other	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown

Specify details of the delay 2:

DELAY 3 - Delays in the provision of adequate and appropriate care at a health facility

Delay Category	Delay Type	Present		
a. Providers of care at time of death	Training of the health care provider was inadequate	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Quality/seniority of the health care provider was inadequate	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Availability of the health care provider was inadequate	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
b. Decision-making process	Serious problem was not recognized	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Correct diagnosis was not made	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Consultation process was lacking	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
c. Actions taken	Referral was not done	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Emergency obstetric care was not done or inadequate	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Appropriate treatment was not given	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Referral was not done	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Emergency obstetric care was not done or inadequate	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Appropriate treatment was not given	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown

Name of Patient:

Medical Record Number:

Delay Category	Delay Type	Present		
d. Delays in referral	Adequate transport was not available	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Financial constraints delayed execution of referral	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Permission (Refusal by sending or receiving facility)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	There was no space available to facilitate a referral	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
e. Facility delays	The services available at the facility were inadequate	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	There were limited or no blood products	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Anaesthesia was not available	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Necessary supplies were inadequate or not available	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Necessary equipment was inadequate or not available	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Necessary medication was inadequate or not available	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Other	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown

Specify details of the delay 3:

Notifier's Details		
Date of Reporting (DD/MM/YYYY): / /		
Comments:		
First Name:		Last Name
Professional Group:		
Phone number:		Email Address:
Name of Institution:		
Parish:		Community:
Office Number/Street Name:		
Health Region: <input type="radio"/> SERHA <input type="radio"/> NERHA <input type="radio"/> SRHA <input type="radio"/> WRHA		
Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H): DD/MM/YYYY

Name of Patient:

| Medical Record Number:

DEFINITIONS

Classification of Death

- **Direct:** Death of a pregnant woman resulting from obstetric complications of pregnancy or its management.
- **Indirect:** Death of a pregnant woman resulting from diseases or conditions that were not due to a direct obstetric cause, but were aggravated by the physiologic effects of pregnancy.
- **Coincidental:** Death of a pregnant woman considered to be causally unrelated to pregnancy.
- **Indeterminate:** Not able to determine a classification for the death of the pregnant woman.

Timing of Death

- **Maternal death:** Death of a woman from direct or indirect causes, during pregnancy, childbirth or within 42 days of the end of the pregnancy, irrespective of the duration and site of the pregnancy.
- **Late maternal death:** Death of a woman from direct or indirect causes, more than 42 days but less than one year after the end of a pregnancy.