Subject: **Forwarding of Maternal Death Auditing Forms & anonymised case sheets - Change in correspondence address**

Dear Presidents and Secretaries,

Warm greetings from the CRMD team.

We would like to bring to your notice about the forwarding of the Maternal Death auditing forms and anonymised case sheets to the CRMD Chairperson .

We request you to convey this message to all your society members during your meetings and follow up with regular reminders, to ensure that no Maternal Death cases are missed for audit.

Please find the prescribed forms attached with this email. These are to be submitted to the following address:

Dr. Jyoti Ramesh Chandran
Chairman, CRMD
Professor & Head, Department of OBG
IMCH, Government Medical College
Kozhikode – 673 008
Kerala, India
Mobile: 9995353512

Your cooperation in this important matter is highly appreciated.

Warm regards,
CRMD Team

Prof. Presanna Kumari B
Chair, Safe Motherhood Committee

Prof. Jyoti Ramesh Chandran
CP, CRMD

CRMD Team 2025–2027

Maternal Death Audit – Form A (1)

Name of the deceased : Age :

Name of husband (if unmarried, name of father) :
Address :

District :

Date of death Time of death Hosp No.

Where death occurred :

Home / on the way / Institution
Name of the Institution
Address

Tel No : Fax: Email :

Doctor in charge

Name
Contact Address

Contact Tel No. Email :

Primary Cause of death : (eg: Hypertension, PPH etc.)

Final cause of death (eg: Renal failure, Multi organ dysfunction etc.)

Duration and status of pregnancy (antenatal, intrapartum, puerperium etc.)

If referred from another centre, details of the referring centre
Name and address of the referring doctor

Name and address of the referring hospital

Name, Designation and

Seal Signature

To

District Medical Officer (HEALTH)
District Medical Office

Maternal Death Audit – Form A (2)

Name of the deceased : Age :

Name of husband (if unmarried, name of father) :
Address :

District :

Date of death Time of death Hosp No.

Where death occurred :

Home / on the way / Institution
Name of the Institution
Address

Tel No : Fax: Email :

Doctor in charge

Name
Contact Address

Contact Tel No. Email :

Primary Cause of death : (eg: Hypertension, PPH etc.)

Final cause of death (eg: Renal failure, Multi organ dysfunction etc.)

Duration and status of pregnancy (antenatal, intrapartum, puerperium etc.)

If referred from another centre, details of the referring centre
Name and address of the referring doctor

Name and address of the referring hospital

Name, Designation and

Seal Signature

To

District Collector
District Collectorate

Maternal Death Audit – Form A (3)

Name of the deceased : Age :

Name of husband (if unmarried, name of father) :
Address :

District :

Date of death Time of death Hosp No.

Where death occurred :

Home / on the way / Institution
Name of the Institution
Address

Tel No : Fax: Email :

Doctor in charge

Name
Contact Address

Contact Tel No. Email :

Primary Cause of death : (eg: Hypertension, PPH etc.)

Final cause of death (eg: Renal failure, Multi organ dysfunction etc.)

Duration and status of pregnancy (antenatal, intrapartum, puerperium etc.)

If referred from another centre, details of the referring centre
Name and address of the referring doctor

Name and address of the referring hospital

Name, Designation and

Seal Signature

To

Additional Director of Health Services (FW)
Directorate of Health Services
General Hospital Junction, Trivandrum

Maternal Death Audit – Form A (4)

Name of the deceased : Age :

Name of husband (if unmarried, name of father) :
Address :

District :

Date of death Time of death Hosp No.

Where death occurred :

Home / on the way / Institution
Name of the Institution
Address

Tel No : Fax: Email :

Doctor in charge

Name
Contact Address

Contact Tel No. Email :

Primary Cause of death : (eg: Hypertension, PPH etc.)

Final cause of death (eg: Renal failure, Multi organ dysfunction etc.)

Duration and status of pregnancy (antenatal, intrapartum, puerperium etc.)

If referred from another centre, details of the referring centre
Name and address of the referring doctor

Name and address of the referring hospital

Name, Designation and

Signature

To

Dr Jyoti Ramesh Chandran
Chairman CRMD,
Professor & Head, Department of OBG
IMCH, Govt. Medical College, Kozhikode - 673 008
Mob: 9995353512

Annexure 2

TO BE KEPT CONFIDENTIAL AT ALL TIMES

FORM B

(To be filled by the Medical Officer in charge)

1.Maternal Death Audit code number

2.Primary (underlying) cause of death……

3.Final (with contributory cause if applicable) cause of death ……

……

4.Where she died:
Level of facility in Which she died (tick one)

1.Primary Level CHC	2. Secondary Level Hospital	3. Tertiary Level Hospital	4. Specialty Hospital	5. Others specify

Government	Private

Date and time of admission

Was she referred ☐ Yes ☐ No If yes from where ☐ Govt ☐ Pvt Level of Hosp ☐ Level 1 ☐ Level 2 ☐ Level 3

Condition on admission

Pulse ☐ BP ☐ Stable ☐ Critical ☐ Moribund ☐ Dead on arrival

5. Basic details

Age at death ☐ Married? ☐ Y or ☐ N

Education of mother NL-Nil, Pr-Primary, Se-Secondary Gr-Graduate, Pr-Professional ☐ Her Occupation

Education of husbands NL-Nil, Pr-Primary, Se-Secondary Gr-Graduate, Pr-Professional ☐ Husbands Occupation

Religion

Distance from home to nearest health facility Km

Hindu	
Muslim	
Sikh	
Christian	
Scheduled Tribe	
Other	

Place of home

Urban	
Urban Slum	
Semi-rural	
Rural	

6. Details at time of death

Gravida ☐ Parity ☐

Gestation in completed weeks If antenatal or at delivery

LMP EDC

Admission at institution where death occurred (if applicable)
Interval between admission and death (if less than 48 hrs please state hours only)
If appropriate interval between delivery and death (if less than 48 hrs please state hours only)

Days	Hours

7. Please identify any antenatal risk factors present / recent pregnancy with Y/N in relevant box.

	Y	N
Hypertension		
Proteinuria		
Glycosuria		
Abnormal Lie		
Severe Anemia		
Previous C-Section		

HIV status?	-ve	+ve
Hbs Ag	-ve	+ve
Was the registered for anaemia treatment under PHN	Y	N
T T	Y	N
Other Please specify		

8. Please mention any other relevant information regarding A/N care and medication

9. Intrapartum care

Had the woman delivered before arrival?

Y	N

If yes where?

Tick one

Home	1.Primary Level CHC	2. Secondary Level Hospital	3. Tertiary Level Hospital	4. Specialty Hospital	5. Others specify

Tick one

Government	Private

Details of labour :

Duration of labour :

	Hrs	Minutes
First Stage		
Second Stage		
Third Stage		

Was a partogram used?

Y	N

Who supervised here labour?

No-one		Registrar or junior	
TBA		GP/other Dr	
Nurse		Other Specify	
Midlife			
Consultant			

Type of delivery

Tick one

Undelivered			
Died during delivery			
Vaginal vertex unassisted			
Vaginal Breech			
Vaginal Assisted		Forceps	Vaccum
Caesarean section		Elective	Emergency

If Caesarean Section state time (hrs and minutes) from decision to perform to actual delivery of baby

Hrs	Mins

Details of antenatal care (ANC)
(Details to be obtained from ANC record with the patient if necessary or available)

Did she receive antenatal care Y/N/NK (not known)

How many ANC visits? (if known)

Where did she receive ANC

Primary level	
Secondary level	
Tertiary level	
Specialty	
At doctor's private consultation	
Others Please specify	

Government	
Private	

Who provided ANC?

Consultant Gynaecologist	
Registrar / Junior Dr	
Medical Officer / GP	
Nurse / JPHN	
TBA	
Others Please specify	

Please provide a short summary of relevant past medical history (eg hypertension, immune disorders, thromboembolism, heart disease, diabetes etc.)

Please provide a short summary of past obstetric history and any previous problems

If there was a delay of morethan 30 minutes to CS, What was this due to?
Was any smooth muscle relexant used?
If assisted vaginal delivery, describe any problem or complications associated with it.
If caesarean, describe any problem ro complications associated with it.

10. Neonatal outcomes

Baby (ies)	Gestation	Birth weight (gms)	Sex	Live Brith M/F	Early neonatal death Stillbirth (Within first 7 days)
1.					
2					
3.					
Please provide any other relevant observations on labour or delivery					

Date & time of labour

Was she induced Yes ☐ No ☐

If yes method of induction

Date & time of rupture of membranes

Drugs used with time & dose for Ripening & induction

Acceleration

Third stage

Was any smooth muscle relaxant used

Drotaverin ☐ Valethamide ☐ Hyoscine ☐

If yes note the time and dose

11. Anaesthesia

GA	Epidural	Spinal	Local

Status of anaesthetist (please circle)

Consultant	Registrar	Junior	Other

12. Postnatal problems
Please describe any postnatal problems including pyrexia, PPH, retained placenta

Was Post Mortem performed?

Y	N

Is there a police case registered?

Y	N

If performed please attach an anonymised copy of the report

13. Results of any pathological investigations (please attach anonymised copies)

14. Please describe the involvement of any other specialist (eg Cardiologist, Nephrologist, anaesthetist).
If their involvement was significant please ask them to provide, and attach, brief anonymised statement of their actions.

15.Your case summary please supply a short case summary of the events leading to her death.

Annexure 3

Form C

Details of Facility based audit

(To be filled by the convener of the audit team)

Maternal Death Audit code No :

Date of audit :

Place of audit :

Audit team Chair

Convener

Members

Cause of death assigned by audit team

Primary cause (eg: PPH, Hypertensive disorders)

Final cause (eg: Renal disease, Multiorgan Failure)

Brief summary of the relevant points noted by the audit team

Brief summary of the positive aspects of management identified by the team

Brief summary of any suboptimal care / deficiencies in hospital facilities / availability of drugs, blood etc, identified by the audit.

Brief summary of any delay or deficiency of service on the part of the patient/ family identified by the audit

Suggestions made by the audit team for future intervention / improvement

Reports prepared by

Name & Designation

Address

Place:

Date:

Forwarded to: Additional Director of Health Services (FW)
Directorate of Health Services
General Hospital Junction, Trivandrum

Annexure 4

Form D

(To be filled by doctor in charge, put in a sealed envelope and given to hospital administration for onward transmission to State coordinator, CRMD.

No names of patients or treating doctors or hospital is to be included in this form except at the tear of part below which will be removed by the state coordinator of CRMD)

1. Can you think of any steps/actions, which if taken earlier, might have prevented this death

2. Any avoidable factors you could identify

3. If you were to treat this patient again what changes in management would you make to avoid maternal death?

4. What else would you recommend for avoiding maternal deaths in similar circumstances?

Name of deceased Date of death

Name of reporting doctor