Government of Kerala

Department of Health & Family Welfare
Directorate of Health Services

Maternal Death Audit

Form A

Name of the Deceased Age

Hosp No Date & time of death

Place of death Hospital ☐ On the way ☐ Home ☐

Cause of death
Primary(eg: PPH, Hypertensive Disease)

Final (eg: Renal failure, Multiorgan dysfunction)
(Please do not put cardiorespiratory arrest as it happens in every death)

Name of husband (or father, if unmarried)

Address

Name and address of the doctor in charge
(where she died)

Tel No email

Address of the hospital
(where she died)

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

Name and address of the referring hospital

signature

Code number

Form B

To be filled by the medical officer in charge(To be kept confidential at all times)

1. Primary (underlying) cause of death
   Date and time of death
2. Final cause of death

3. Where she died Facility / Home / On the way
   Level of the facility where she died Primary Secondary Tertiary
   Was she referred Yes No
   If referred, level of that facility Primary Secondary Tertiary
   Govt. Private
4. Date and time of admission ----------

   Date of delivery ----------

   Condition on admission Stable Critical Moribund Dead

5. Basic Details

Age Married Yes / No
Religion Hindu, Muslim, Christian,
Place of Home Urban Rural Tribal

Education of the deceased Nil Primary Secondary Graduate or above

Occupation of the deceased

Education of the husband Nil Primary Secondary Graduate or above

Occupation of the husband

6. Details at time of death

Gravida Para Gestation in completed weeks

LMP EDC

Interval between admission and death ------- Days/ hrs
Interval between delivery and death Days /hrs

7. Did she receive regular AN care? Y/N Mention any relevant information and medications

Relevant Past medical & obstetric history

Mention any known risk factors present

8. Intrapartum care

Had the woman delivered before arrival Yes / No
Who conducted the delivery Doctor / Nurse
Type of delivery
Abortion Ectopic
Undelivered, Died during labour
Vaginal vertex unassisted Vaginal breech
Vaginal assisted - Forceps/ vacuum
Cesarean section - Elective / Emergency / Classical /Peri mortem
Anesthesia - Spinal / General

If emergency CS, time taken from decision to actual surgery
If there was delay of more than 30 minutes to do CS, what was this due to ?

Cesarean findings (in relevant cases), any problems or complications associated with it?

9. Neonatal outcome

Baby	Gestation	Wt.	Sex	Live birth	Stillbirth	Neonatal death
1						
2						

10. Was labour induced? Yes / No If Yes, method of induction
(Foleys, Drugs (dose & timings), Acceleration etc).

Was any smooth muscle relaxant used?
(Name of the drug, dose and time, eg: Epidosine, drotaverine, hyosine)

AMTSL - Give Details

11. Postnatal problems (Fever, PPH etc)

Cause of PPH -- Atonic /Traumatic / Placenta previa / Retained placenta

How did you manage PPH

Was surgery done? Give details

If she had hypertensive disease

When was hypertension detected?

Drugs given in A/N period

Was there chronic hypertension, pre-eclampsia Eclampsia HELLP

Cerebral hemorrhage

Did she receive Magnesium sulphate - when & dose

Did she receive antihypertensives - drug, dose & time

12. Was postmortem performed? Yes / No (If yes attach a copy of the report)
13. Relevant investigation results

14. Mention involvement of other specialists

15. Short summary of the case

Annexure 3

Details of Facility based audit

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

Maternal death audit No:

Date of audit: Date of death

Name of the patient:

Name and address of the hospital:

Audit team Chair:

Members:

Cause of death assigned, Primary:

Final:

Brief Summary of the case:

Any deficiencies in hospital facilities, drugs, blood noted:

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