Health-facility Based Maternal Death Audit Form
— this form can be adapted to fit individual circumstances —

THIS FORM MUST BE KEPT PRIVATE AND CONFIDENTIAL AT ALL TIMES AND NO PHOTOCOPIES ARE TO BE MADE. WHEN NOT IN USE IT MUST BE LOCKED IN A SECURE PLACE.

The most senior health worker who attended to the deceased will complete Section A. Additionally, health personnel notes, maternity records, and any pathological findings and autopsy reports could be attached if available. However these records must remain anonymous. Other health workers who also saw or attended to the deceased will fill Section B of the form. Section C is for the interview with the deceased’s family members. Section D is for the findings of the audit committee.

Section A

Type of facility: 
- Private clinic
- Provincial/regional/state hospital
- Health center
- District hospital
- Teaching hospital

Operating authority: 
- Government
- Private for-profit
- Faith-based
- NGO
- Other

Age: __________________________
Date of death: __________________________
Time of death: __________________________
Place of death: 
- Home
- Health facility
- On the way to the health facility

Referred: 
- Yes
- No
If Yes, how far (distance) __________________________
Referred from where __________________________

Residence: 
- Rural
- Urban

Marital status: 
- Married
- Never married
- Separated/divorced
- Widowed

Highest level of school attended: 
- None
- Primary
- Secondary
- Higher
- Don’t know

Occupation of deceased: __________________________
Occupation of husband/partner: __________________________
Religion: __________________________ (provide appropriate choices to allowed standardized reporting)
Ethnicity: __________________________ (provide appropriate choices to allowed standardized reporting)
N of previous live births: __________
N of previous stillbirths: __________
N of previous miscarriages/abortion: __________

Main attendant at delivery: 
- Obstetrician
- Medical officer
- Nurse/midwife
- Traditional birth attendant
- Other

Years of training/experience of the main attendant:
Gestation in weeks on presentation to health facility (if applicable): __________
Gestation in weeks at time of delivery or death if undelivered: __________
Days after delivery if postpartum death: __________
Details of this pregnancy

Outcome of pregnancy: □ Live birth □ Stillbirth □ Miscarriage
□ Induced abortion □ Ectopic pregnancy □ Died before delivery

Antenatal care: □ Yes □ No N of visits__________

Place of antenatal care: □ Private clinic □ Health center □ District hospital
□ Provincial/regional/state hospital □ Teaching hospital

Past medical history: ____________________________________________ Past obstetric history: ______________________________

Please provide a summary of her antenatal period, including any problems that might have arisen:
____________________________________________________________________________________

Admission to hospital

Date of arrival (admission) in your facility: __________________________

Time of arrival (admission) in your facility: __________________________

Days after delivery on admission if delivered: ________________________

Clinical details

Describe what happened from the time of admission to this facility until she died:
____________________________________________________________________________________

Please describe any factors before arrival at this facility which delayed or affected the woman’s condition (such as treatment from traditional health attendant, lack of transport, inability to pay fees, etc.):
____________________________________________________________________________________

Pregnancy/antenatal care history:
____________________________________________________________________________________

Labor/delivery/postnatal history as well as condition/complications on arrival:
____________________________________________________________________________________

Clinical examination findings, laboratory tests, etc. Attach all laboratory results and postmortem reports (without personal identifying information):
____________________________________________________________________________________

Treatment given (including surgical and anesthetic):
____________________________________________________________________________________

What, in your opinion, was her probable cause of death?

Was this confirmed by autopsy or other pathological diagnosis?
____________________________________________________________________________________

Did you consider any alternative diagnoses?
____________________________________________________________________________________

Please list any contributory factors:
____________________________________________________________________________________

Job title of senior health worker: ________________________________

Date: ________________
**Section B**

Narrative by other health worker(s) who attended to deceased:

______________________________________________________________________________  

Job title of other health worker:_____________________________________________________

Date:____________________

**Section C**

**Narrative from family member**

Relationship to deceased:  _________________________________________________________

Could you tell me about everything that happened during the last illness before (NAME OF DECEASED) death, starting from the beginning of her pregnancy, through her illness and about what happened during the final hours of the woman's death?

Prompt: Was there anything else?

INSTRUCTIONS TO INTERVIEWER – ALLOW THE RESPONDENT TO TELL YOU ABOUT THE ILLNESS IN HIS OR HER OWN WORDS. DO NOT PROMPT EXCEPT FOR ASKING WHETHER THERE WAS ANYTHING ELSE AFTER THE RESPONDENT FINISHES. KEEP PROMPTING UNTIL THE RESPONDENT SAYS THERE WAS NOTHING ELSE.

Please describe what happened from the start of her pregnancy until she died.

______________________________________________________________________________

Can you give me more details about the circumstances of her actual death?

______________________________________________________________________________

What treatment did she get at the health facility or other places where she received treatment?

______________________________________________________________________________

If no treatment was sought, why?

______________________________________________________________________________

What do you think was the cause of her death?

______________________________________________________________________________

What do you think could have changed the outcome and prevented the death of (NAME OF DECEASED)?

______________________________________________________________________________

Are there any messages you would like to give those who are in charge of maternity services about how the care for pregnant women can be improved?

______________________________________________________________________________

Thank you
Section D

Findings of audit committee

Name and titles of audit committee members:
________________________________________________________________________________________

Final agreed cause of death:
________________________________________________________________________________________

____ ICD-10 code cause of death: ____________________________________________________________

Contributory factors:
________________________________________________________________________________________

Was care substandard? In which respects – clinical, health system, or other?
________________________________________________________________________________________

What can be learnt from this death?
________________________________________________________________________________________

What recommendations do you make for doing things differently in future?
________________________________________________________________________________________

How are you going to achieve this?
________________________________________________________________________________________

____ Chair of Audit

committee:________________________________________________________________________________

Date: ____________________________