National Surveillance Unit, National Epidemiology Branch,
15 Knutsford Boulevard, Kingston 5,
Email: surveillance@moh.gov.jm, Telephone 876-633-7937

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)

◯ Antenatal ward	◯ Accident & Emergency	◯ ICU / HDU
◯ Labour ward	◯ Operating theatre	◯ Postnatal ward
◯ Non-obstetrics ward	Non-obstetrics ward:	

Classification of Death

◯ **Direct**	◯ **Coincidental**
◯ **Indirect**	◯ **Indeterminate**

Timing of Death

◯ **Maternal death**	◯ **Late maternal death**

Type of Death

◯ **Avoidable**	◯ **Unavoidable**	◯ **Unknown**

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	◯ Yes	◯ No	◯ Unknown
	Patient delayed seeking care	◯ Yes	◯ No	◯ Unknown
	Previous poor experience with health care	◯ Yes	◯ No	◯ Unknown
	Other	◯ Yes	◯ No	◯ 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	◯ Yes	◯ No	◯ Unknown
	Delayed access due to transportation	◯ Yes	◯ No	◯ Unknown
	Other	◯ Yes	◯ No	◯ Unknown
		◯ Yes	◯ No	◯ 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	◯ Yes	◯ No	◯ Unknown
	Quality/seniority of the health care provider was inadequate	◯ Yes	◯ No	◯ Unknown
	Availability of the health care provider was inadequate	◯ Yes	◯ No	◯ Unknown
b. Decision-making process	Serious problem was not recognized	◯ Yes	◯ No	◯ Unknown
	Correct diagnosis was not made	◯ Yes	◯ No	◯ Unknown
	Consultation process was lacking	◯ Yes	◯ No	◯ Unknown
c. Actions taken	Referral was not done	◯ Yes	◯ No	◯ Unknown
	Emergency obstetric care was not done or inadequate	◯ Yes	◯ No	◯ Unknown
	Appropriate treatment was not given	◯ Yes	◯ No	◯ Unknown
	Referral was not done	◯ Yes	◯ No	◯ Unknown
	Emergency obstetric care was not done or inadequate	◯ Yes	◯ No	◯ Unknown
	Appropriate treatment was not given	◯ Yes	◯ No	◯ Unknown

Name of Patient: | Medical Record Number:

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