

QUEENSLAND MATERNAL AND PERINATAL QUALITY COUNCIL

National Maternal Death Report form

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Instructions

Instructions

1. Please do not enter the patient's name, address or hospital number on this form.
2. Please record the unique case ID number.
3. Fill in the form using as much detail as possible from the information available in the woman's case notes and any other available resources.
4. Tick the boxes as appropriate. If you require any additional space to answer a question please use the comments box provided at the end of this form noting the specific question number.
5. Please complete all dates in the format DD/MM/YY, unless otherwise indicated.
6. Definition of each variable is contained in the data dictionary.
7. If you encounter any problems with completing this form, please contact the QMPQC secretariat 07 36466880

Definition

A maternal death is 'the death of a woman while pregnant or within 42days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes'.

For the purpose of this survey, all cases of a woman dying during pregnancy or within 42days of termination of pregnancy, miscarriage or giving birth are required to be reported.

Valid response

A case is defined as any woman identified as having died during pregnancy or in the 42 days postpartum period.

How to complete the form

This form has three parts: Parts A, B and C. All 'Parts' of the form should be completed.

PART A has 18 sections. It is not necessary to complete all sections in PART A.

PART B has 5 sections. It is not necessary to complete all sections in PART B.

PART C has 1 section. PART C Should be completed by the State and Territory Maternal Mortality Committee and where information is available, please complete all of PART C.

PART A:

- Section 1: Details of Death
- Section 2: Demographic details
- Section 3: Maternal Characteristics
- Section 4: Past Obstetric History
- Section 5: Past Medical History
- Section 6: Details of Pregnancy
- Section 7: Details of Labor
- Section 8: Details of Caesarean Section
- Section 9: Details of Birth
- Section 10: Details of postnatal period
- Section 11: Place of Death
- Section 12: Reflection
- Section 13: Deaths following Miscarriage

- Section 14: Deaths following Termination of Pregnancy
- Section 15: Deaths following ectopic pregnancy
- Section 16: Deaths in early pregnancy due to other causes
- Section 17: Deaths due to Thromboembolism
- Section 18: Deaths due to Sepsis

PART B:

- Section 1: Anesthetic Report
- Section 2: Pathology report
- Section 3: Deaths in the Emergency Department
- Section 4: Deaths in a Critical Care Unit
- Section 5: Deaths related to Psychosocial Morbidity

PART C

To be completed by the State and Territory Maternal Mortality Committee.

Checklist

1. Health professionals involved in this woman's care

	Yes	No
Obstetrician	<input type="radio"/>	<input type="radio"/>
Midwife	<input type="radio"/>	<input type="radio"/>
Physician	<input type="radio"/>	<input type="radio"/>
Psychiatrist	<input type="radio"/>	<input type="radio"/>
Emergency Medicine Specialist	<input type="radio"/>	<input type="radio"/>
Critical Care Specialist	<input type="radio"/>	<input type="radio"/>
Surgeon	<input type="radio"/>	<input type="radio"/>
Pathologist	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

Other (please specify)

2. Please complete the checklist below

	Yes	No
Relevant maternity notes (medical notes, discharge summaries, antenatal records etc.) attached	<input type="radio"/>	<input type="radio"/>
Critical care discharge summary attached	<input type="radio"/>	<input type="radio"/>
Local hospital incident reports attached	<input type="radio"/>	<input type="radio"/>
Coroners report attached	<input type="radio"/>	<input type="radio"/>
Suicide report attached	<input type="radio"/>	<input type="radio"/>

PART A - Section 1 Details of Death

3. State case number or study specific ID

4. Direct cause of death (as specified on medical death certificate)

5. Antecedent cause of death (as specified on medical death certificate)

6. Date of death

7. Maternal age at delivery (yrs)

8. Maternal age at death (yrs)

9. If death occurred antepartum; gestational age at death (weeks)

10. Pregnancy status of mother at time of death, if less than 20 weeks gestation

- Pregnant Ectopic Unknown
- Miscarriage Molar
- Termination of pregnancy Other

11. Pregnancy status of mother at time of death, if greater than 20 weeks gestation

- Antepartum Postpartum <42 days Unknown
- Intrapartum Postpartum >42 days Other

12. If death occurred postpartum; number of days postpartum that death occurred

Days

13. Length of hospital stay for birth admission (days)

PART A - Section 2 Demographic details

14. State of usual residence

- NT ACT Other Territories
 QLD WA Non- Australian resident
 NSW TAS
 VIC SA

15. Postcode of usual residence

16. Country of birth

17. Main Language spoken at home

- English

Other (please specify)

18. Was an interpreter required to communicate with this woman?

- Yes No Unknown

19. If an interpreter was required, choose one of the following

- No interpretation provided Professional interpretation used
 Friend or relative interpreted Unknown

20. Length of time in Australia

- Less than 1 year Born in Australia
 More than 1 year Unknown

21. Main occupation

22. Marital status

- Never married/single Divorced Married (including de facto)
 Widowed Separated Other

23. Woman's living arrangements at the time of her death

- Living with family Living alone
 Living with others Unknown

24. Health Insurance status

- Public Private Other

25. Torres Strait Islander or Aboriginal status

- Indigenous - Aboriginal
- Indigenous - Aboriginal and Torres Strait Islander
- Indigenous - Torres Strait Islander
- Non-Indigenous
- Unknown

PART A - Section 3 Maternal Characteristics

26. Body Mass Index at first antenatal visit

27. Maternal height at first antenatal visit

cm

28. Maternal weight at first antenatal visit

Kg

29. If BMI unknown, was the woman obese?

- Yes No Unknown

30. Illicit drug use during pregnancy or up to 42 days postpartum

- None Amphetamines and ecstasy
 Cannabis Cocaine
 Opiates/opioids Abuse of prescription medications
 Benzodiazepines Unknown

Other (please specify)

31. Did the woman smoke during the first 20 weeks of pregnancy?

- Yes No Unknown

32. If the woman smoked during the first 20 weeks of pregnancy, what was the average number of cigarettes smoked per day?

33. Did the woman smoke after 20 weeks of pregnancy?

- Yes No Unknown

34. If the woman smoked after 20 weeks of pregnancy what was the average number of cigarettes smoked per day?

35. Did the woman use alcohol during pregnancy or up to 42 days postpartum?

- Yes No Unknown

36. Was the woman in prison during pregnancy or up to 42 days postpartum?

- Yes No Unknown

37. Has this woman experienced domestic violence during the pregnancy or up to 42 days postpartum?

- Yes No Unknown

38. Was domestic violence screening undertaken?

Yes

No

Unknown

39. Was antenatal mental health screening undertaken?

Yes

No

Unknown

40. Was postnatal mental health screening undertaken?

Yes

No

Unknown

41. Was the woman a known sex worker?

Yes

No

42. Was this woman known to Child Protection Services?

Yes

No

Unknown

43. Were any of this woman's children in care?

Yes

No

Unknown

44. Was the newborn to be taken into care?

Yes

No

Unknown

45. Was this woman referred to or under the care of a mental health services during pregnancy or the post natal period?

Yes

No

Unknown

PART A - Section 4 Past Obstetric History

46. Parity (at the beginning of this pregnancy)

47. Gravidity

Number of live births

Number of still births

Number of pregnancies

<20 weeks gestation or
400gram birthweight

48. Previous Caesarean Section

- No previous birth by caesarian section Two or more previous births by caesarean section
- One previous birth by caesarean section Unknown

49. Was a caesarean section performed for the last birth?

- Yes No Unknown

50. Did the woman have any complications in past pregnancies?

- | | |
|---|---|
| <input type="checkbox"/> Not applicable (no previous pregnancies) | <input type="checkbox"/> Mental illness occurring during or up to 42days postpartum |
| <input type="checkbox"/> None | <input type="checkbox"/> Acute Fatty liver |
| <input type="checkbox"/> Antepartum Haemorrhage | <input type="checkbox"/> Pre-eclampsia/ Eclampsia |
| <input type="checkbox"/> Postpartum Haemorrhage (600mls +) | <input type="checkbox"/> Gestational Hypertension |
| <input type="checkbox"/> Placenta Accreta | <input type="checkbox"/> Placenta Praevia |
| <input type="checkbox"/> Amniotic Fluid Embolism | <input type="checkbox"/> Puerperal Sepsis |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Admission to ICU during pregnancy |

Other (please specify)

PART A - Section 5 Past Medical History

51. Was the woman tested for any of the following?

	Positive	Negative	Not Tested
HIV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Syphilis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis C	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rubella	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

52. Pre-existing medical conditions (indicate as appropriate)

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Renal disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malignancy |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pulmonary hypertension |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Thromboembolic event |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Asthma requiring medication |

Other (please specify)

53. If relevant please provide details of any pre-existing medical conditions

54. Please provide details of any relevant surgical history

55. Was this pregnancy post organ transplantation

- Yes No Unknown

If yes, please comment

PART A - Section 6 Details of Pregnancy

56. Was this pregnancy the result of fertility treatment?

- Yes No Unknown

57. Type of fertility treatment (if applicable)

- None Ovulation Stimulation
 Artificial Insemination Other
 Assisted reproductive technology Unknown
 Ovulation Induction

58. How many antenatal visits did this woman attend?

- None 5 or more visits
 1 visit Unknown
 2 to 4 visits

59. Gestation at first antenatal visit

Weeks

60. Number of missed antenatal visits

61. If this woman was a poor attendee at antenatal visits, was this followed up?

- Yes No Unknown

62. With whom was the woman booked for antenatal care?

- Case midwifery care GP Shared care: with other doctor (e.g. cardiologist)
 Team midwifery care Shared care: Midwife and GP
 Private Obstetrician Shared care: Midwife and Obstetrician Aboriginal maternity care
 Public Obstetrician Shared care: GP and Obstetrician

Other (please specify)

63. Was there a transfer of care at any point during pregnancy?

- Yes No Unknown

If yes, why?

64. Intended place of birth at less than 20 weeks gestation

- Hospital, excluding birth center Birth center, free-standing Unknown
 Birth center, attached to hospital Home

Other (please specify)

65. Complications in this pregnancy

- | | | |
|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Ectopic Pregnancy | <input type="checkbox"/> Gestational Hypertension |
| <input type="checkbox"/> Antepartum Haemorrhage | <input type="checkbox"/> Amniotic Fluid Embolism | <input type="checkbox"/> Acute Fatty Liver |
| <input type="checkbox"/> Placenta Praevia | <input type="checkbox"/> Puerperal Sepsis | <input type="checkbox"/> Mental illness occurring during pregnancy or up to 42 days post partum |
| <input type="checkbox"/> Placenta Accreta | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Pregnancy admission to ICU |
| <input type="checkbox"/> Postpartum haemorrhage (600ml+) | <input type="checkbox"/> Pre-eclampsia | <input type="checkbox"/> Multiple pregnancy |

Other (please specify)

66. Please supply further details of any pregnancy complications, including a discussion of the management plan

67. Were there any episodes of vaginal bleeding at less than 20 weeks gestation?

- Yes No Unknown

68. Were there any episodes of vaginal bleeding at greater than 20 weeks gestation?

- | | |
|--|---|
| <input type="radio"/> None | <input type="radio"/> Yes - Placenta Praevia |
| <input type="radio"/> Yes - Fetal bleeding | <input type="radio"/> Yes - Lower genital tract |
| <input type="radio"/> Yes - Abruption | <input type="radio"/> Unknown |

Other (please specify)

69. Were any antenatal procedures performed? If yes, please provide details

- Yes No Unknown

Please provide details

70. Was this woman admitted to hospital during the antenatal period? if yes, please give details

Yes

No

Unknown

Please provide details

71. Was this woman re-admitted to hospital during the antenatal period? If, yes please give details

Yes

No

Unknown

Please provide details

PART A - Section 7 Details of Labour

If no labour complete questions 63 only and proceed to section 8.

72. Onset of labour

- Spontaneous No labour
 Induced Unknown

73. Length of the first stage of labour

Minutes

74. Length of the second stage of labour

Minutes

75. Length of the third stage of labour

Minutes

76. Primary caregiver at the onset of labour

- Not applicable Other doctor GP
 Obstetrician GP obstetrician No birth attendant
 Registrar/RMO Midwife Unknown

Other (please specify)

77. Was a referral made to the Obstetric team during labour?

- Not applicable Yes No Unknown

78. Was there a delay in obtaining help at any stage? (tick all that apply)

- No Other medical help Neonatal resuscitation
 Consultant obstetrician help Midwifery help Delay in laboratory testing
 consultant other Ambulance services Blood products
 Other obstetric medical help Consultant anesthetist

Other (please specify)

79. Type of induction of labour

- None Prostaglandins Combined types (oxytocin/ARM/other)
 Oxytocin Artificial rupture of membranes (ARM)

Other (please specify)

80. Main reason for induction of labour (if applicable)

- Not applicable
- Prolonged pregnancy
- Psychosocial
- Hypertension/pre-eclampsia
- Premature rupture of membranes
- Diabetes
- Intrauterine growth restriction
- Foetal death
- Foetal distress
- Isoimmunisation
- Chorioamnionitis
- Unknown

Other (please specify)

81. Type of augmentation of labour

- None
- Oxytocin
- Prostaglandins
- Artificial rupture of membranes
- Combined types
- Unknown

Other (please specify)

82. Treatment during labour

- None
- Syntocinon
- IV fluids
- MGSO4
- Anticonvulsants
- Antihypertensives
- Operative abdominal procedure
- Unknown

Other (please specify)

83. Type of analgesia administered to the mother to relieve pain during labour and delivery

- None
- Nitrous Oxide
- Intra-muscular injection
- Epidural
- Combined spinal and epidural
- Spinal
- Unknown

Other (please specify)

84. Active management of the third stage of labour?

- Yes
- No
- Unknown

85. Were the membranes and placenta complete?

- Yes
- No
- Unknown

86. Perineal tear (1st,2nd,3rd,4th)

- Yes
- No
- Unknown

87. Estimated blood loss during third stage

mls

88. Peripartum hysterectomy?

Yes

No

Unknown

PART A - Section 8 Details of Delivery by Caesarean Section

Complete if caesarean section performed for this pregnancy otherwise proceed to section 9.

The anesthetist involved in this case to please complete PART B - Section 1

89. Timing of caesarean section

- Before labour Onset of labour After labour

90. Type of caesarean section

91. Please list procedures tried before caesarean section

92. Reason for Caesarean Section

- Previous caesarean section Psychosocial/elective/patient choice Intrauterine growth restriction
- Failure to progress/cephalopelvic disproportion Antepartum haemorrhage Not stated
- Foetal distress Hypertension/ pre-eclampsia
- Malpresentation Multiple pregnancy

Other (please specify)

93. Category of caesarean section

- Immediate threat to life of woman or baby
- Maternal or foetal compromise with no immediate threat to life
- No maternal or foetal compromise but needs early delivery
- Delivery timed to suit woman or staff
- Peri or postmortem
- Unknown

94. Qualifications of obstetrician performing and assisting in caesarean section

	Doctor 1	Doctor 2	Doctor 3
Consultant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Registrar/RMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

95. Was thromboprophylaxis administered

- Yes No Unknown

PART A - Section 9 Details of Birth

If no birth, please complete question 82 and go to PART A- Section 11 Place of Death

In addition to PART A - Section 11:

For deaths following miscarriage complete PART A - Section 13

For deaths following termination of pregnancy complete PART A - Section 14

For deaths following ectopic pregnancy complete PART A - Section 15

For deaths due in early pregnancy from other causes complete PART A - Section 16

96. Was the woman undelivered at the time of death?

- Not applicable Yes No Unknown

If yes please go to section 11 - Place of Death

97. Actual place of birth

- Not applicable Birth center, attached to hospital Home
 Hospital, excluding birth center Birth center, free standing Unknown

Other (please specify)

98. Birth attendant

- Not applicable Other doctor GP
 No birth attendant GP Obstetrician Unknown
 Registrar/RMO Midwife Obsetrican

Other (please specify)

99. Was the birth attendant known to the woman prior to the onset of labour?

- Yes No Unknown

100. Type of birth

- Not applicable Caesarean section Unknown
 Vaginal - non instrumental Vaginal - vacuum extraction
 Vaginal - forceps Foetal retrieval

101. Plurality of birth

- Singleton Quadruplets Unknown
 Twins Qunituplets
 Triplets Sextuplets

Other (please specify)

102. Birth status

	Live birth	Still birth	Neonatal death
Baby 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Baby 2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Baby 3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PART A - Section 10 Details of Postnatal Period

103. What was the length of this woman's postnatal stay?

Days

104. Were there any puerperal complications?

- | | | |
|--------------------------------------|--|----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Pre-eclampsia/eclampsia | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Haemorrhage | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Sepsis | <input type="checkbox"/> Thromboembolism | |

Other (please specify)

105. Was the Haemoglobin level checked postpartum?

- Yes No Unknown

If yes, please state on which days

106. Did the woman require a blood transfusion?

- Yes No Unknown

If yes, how many units were required

107. Was the mother discharged from hospital after giving birth/miscarriage/termination of pregnancy and prior to her death?

- Yes No Unknown

108. Was she re-admitted to hospital prior to her death?

- Yes No Unknown

109. How many post natal visits did the woman attend? (either at home or at the hospital)

- | | |
|----------------------------|------------------------------------|
| <input type="radio"/> None | <input type="radio"/> Three |
| <input type="radio"/> One | <input type="radio"/> Four or more |
| <input type="radio"/> Two | <input type="radio"/> unknown |

PART A - Section 11 Place of death

110. Was the woman transferred between health care facilities before giving birth/miscarriage/termination of pregnancy

- Yes No Unknown

111. Was the woman transferred between health care facilities during giving birth/miscarriage/termination of pregnancy?

- yes No Unknown

112. Was the woman transferred between health care facilities after giving birth/miscarriage/termination of pregnancy

- Yes No Unknown

113. Distance of transfer

km

114. Did the woman die in transit?

- Not applicable Yes No Unknown

115. Place of death

- Hospital, excluding birth centre, Birth centre, free standing Unknown
 Birth centre attached to hospital Home

Other (please specify)

116. If place of death was hospital, was it

- Hospital in which she booked to deliver Unbooked admission
 An emergency transfer from elsewhere Unknown

Other (please specify)

117. If the death was in hospital, did it occur outside of the maternity ward?

- Not applicable Emergency Department Surgical theatres
 No Coronary Care Unit Gynae ward
 Death in Intensive Care Unit Psychiatric Unit Unknown
 High Dependency Unit Obstetric theatres

Other (please specify)

118. If death was in hospital was the woman dead on arrival?

- Not applicable Yes No Unknown

119. Hospital level

- Not applicable
- Level 1
- Level 2
- Level 3
- Level 4
- Level 5
- Level 6
- Unknown

120. Hospital sector

- Not applicable
- Public
- Private
- Unknown

121. Hospital accommodation status

- Not applicable
- Public
- Private
- Unknown

122. Was this case reported to the coroner?

- Yes
- No
- Unknown

123. If the death occurred in hospital, was the death identified and reported as a serious incident?

- Not applicable
- Yes
- No
- Unknown

124. Please provide a summary of the circumstances surrounding this woman's death

|

PART A - Section 13 Death from Miscarriage

Complete only if death occurred following miscarriage. Otherwise leave blank and go to section 14.

130. Was this a

- Complete miscarriage
- Missed miscarriage
- Incomplete miscarriage
- Hydatidiform mole/trophoblastic disease

131. Please describe the circumstances surrounding this woman's death (including details of treatment provided)

PART A - Section 14 Deaths Following Termination of Pregnancy (TOP)

Complete only if death occurred following termination of pregnancy.
Otherwise leave blank and go to section 15.

132. Number of days following termination of pregnancy that death occurred

Days

133. Gestation at time of termination of pregnancy

134. Was the termination of pregnancy (tick all that apply)

- | | | |
|-----------------------------------|---|---------------------------------|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Overnight stay | <input type="checkbox"/> Public |
| <input type="checkbox"/> Surgical | <input type="checkbox"/> Legal | |
| <input type="checkbox"/> Day case | <input type="checkbox"/> Private | |

Other (please specify)

135. Please provide a summary of the circumstances surrounding this woman's death

|

PART A - Section 15 Deaths Following Ectopic Pregnancy

Complete only if death occurred following ectopic pregnancy. Otherwise leave blank and go to section 16.

136. Did the woman know she was pregnant?

Yes

No

Unknown

137. Was the diagnoses confirmed by ultrasound?

Yes

No

Unknown

138. Please provide a summary of the circumstances surrounding this woman's death

|

|

PART A - Section 16 Deaths in early pregnancy from other causes

Complete if death occurred in early pregnancy due to a cause other than miscarriage/termination of pregnancy or ectopic.

Otherwise leave blank and go to section 17.

139. Please provide details of the circumstances surrounding this woman's death

PART A - Section 17 Deaths from Thromboembolism

Complete if a diagnosis of thromboembolism was made during pregnancy or up to 1 year after birth.
Otherwise leave blank and go to section 18.

140. Gestation at diagnosis

Weeks

141. OR

Days post partum at diagnosis

Days

142. Site of thrombosis

143. Site of embolism

144. Did this woman have a previous history of Pulmonary Embolism?

- Yes No Unknown

145. Did this woman have a thrombophilia screen?

	Positive	Negative	Not tested
Thrombophilia screen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

146. If this woman had a previous history Pulmonary Embolism, was it pregnancy related?

- Not applicable No
 Yes Unknown

147. Were there any other risk factors for pulmonary embolism?

- None Hormonal contraception Previous history of DVT
 Recent long journey Active cancer Obesity

148. Did this woman receive pharmacological thrombo-prophylaxis during pregnancy or whilst giving birth?

If yes, please provide details of regime administered

- No Low Molecular Weight Heparin Unknown
 Unfractionated heparin Warfarin

Further details of thromboprophylaxis regime

149. Were non pharmacological thrombo-prophylactic measures used?

- No Intermittent pneumatic compression
 Compression stockings Unknown

150. Did this woman receive therapeutic anti coagulation during pregnancy or whilst giving birth?

- Not applicable Yes - Low Molecular weight Heparin No
 Yes - Fractionated heparin Yes - Warfarin Unknown

151. Was therapeutic anticoagulation continued for 6 months post partum?

- Not applicable No
 Yes Unknown

If no, why was therapy stopped?

152. Please provide a summary of the circumstances surrounding this woman's death

PART A - Section 18 Deaths from Sepsis

Please complete if death was related to sepsis.
Otherwise leave blank and go to PART B.

153. Were specimens for micro-organisms taken?

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Cerebro-Spinal Fluid (CSF) | <input type="checkbox"/> Other sites |
| <input type="checkbox"/> Mid Stream Urine (MSU) | <input type="checkbox"/> Vaginal swabs | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Placental swabs | <input type="checkbox"/> Blood cultures | |

154. Which organism was identified?

155. Please provide details of antibiotic therapies used

156. Were there any associated organ failures in this case?

- | | | |
|---|---|----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Cardiac failure | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Respiratory failure requiring mechanical ventilation | <input type="checkbox"/> Liver failure | |
| <input type="checkbox"/> Renal failure requiring renal replacement therapy | <input type="checkbox"/> Multiorgan failure | |

157. Please provide a summary of the circumstances surrounding this woman's death (including any lab results)

|

PART B - Section 1 Anaesthesia Report

To be completed by the anaesthetist caring for this woman

158. Reason for analgesia/anaesthesia

159. Was there an antenatal or pre-operative consultation

- Yes No Unknown

160. Was there consultation during labour?

- Yes No Unknown

161. Type of anaesthesia administered

- None Epidural Combined spinal-epidural
 Local anaesthetic to perineum Spinal Unknown
 Pudendal General anaesthetic

Other (please specify)

162. Monitoring used

- None CVP NIBP
 ECG Intra-arterial blood pressure
 Capnography Pulse oximetry

Other (please specify)

163. Where was the anaesthetic given (geographical location)?

- Obstetric ward Other surgical ward Unknown
 Other medical ward Theatres

Other (please specify)

164. If conversion from regional to general anaesthesia took place, please state the reason why and where this occurred.

165. Were there any difficulties with intubation?

- Not applicable
- unanticipated difficult airway
- anticipated difficult airway
- Unknown

166. What was the grading of the view obtained at laryngoscopy?

- Not applicable
- Grade 2
- Grade 4
- Grade 1
- Grade 3
- Unknown

How was it managed?

167. Was an appropriately qualified assistant available at the time?

- Yes
- No
- Unknown

168. Was the consultant on call informed at any time?

- Yes
- No
- Unknown

169. Was the consultant on call present at any time during the procedure?

- Yes
- No
- Unknown

170. Did a full recovery occur?

- Yes
- No
- Unknown

171. Where did the recovery occur?

- Not applicable
- High dependency unit
- Obstetric theatre
- Intensive care unit
- Recovery room
- Coronary care unit

Further details of any problems with recovery

**172. What do you think can be learnt from this case?
has it changed your individual practice?**

PART B - Section 2 Pathology report

173. Was an autopsy performed?

- Yes No Unknown

174. Did the coroner authorise an autopsy?

- Yes No Unknown

175. If the coroner did not authorise an autopsy, was an autopsy requested by clinicians?

- Yes No Unknown

176. Did the family consent to an autopsy?

- Yes No Unknown

177. Please summarise the autopsy findings and attach the report if available

178. Please summarise the toxicology report

179. What do you think can be learnt from this case? Has it changed your individual practice?

PART B - Section 3 Deaths in the Emergency Department

To be completed by the most senior Emergency Medicine clinician involved in this woman's care

180. How long did this woman wait for her first assessment in the Emergency Department?

Hours

181. Who was she first triaged by?

- None Junior doctor Midwife
 Triage nurse Consultant Emergency Medicine Unknown
 Senior nursing staff Junior Obstetrician/Gynaecologist

Other (please specify)

182. If she was referred to another team, how long did she wait to be seen?

Hours

183. Who did she see in the Emergency Department?

- None Consultant Emergency medicine Midwife
 Senior nursing staff Junior Obstetrician/Gynaecologist Unknown
 Junior doctor Consultant Obstetrician

Other (please specify)

184. What was the diagnosis?

185. Was this woman discharged from the Emergency Department prior to her death?

- Yes No Unknown

186. Was the woman re-admitted to hospital following discharge from the Emergency Department and prior to her death?

- Yes No Unknown

Please provide details

187. How many times did this woman present to the Emergency Department during her pregnancy?

188. What do you think can be learnt from this case?

Has it changed your individual practice?

PART B - Section 4 Deaths following admission to a Critical Care Unit

To be completed by the Consultant in charge of the critical care unit (ICU/HDU/CCU)

If the woman was cared for in more than one critical care unit please copy this section of the form and complete for each admission.

189. Was this woman admitted to

Intensive Care Unit

Coronary Care Unit

High Dependency Unit

Other (please specify)

190. What was the reason for admission?

191. Was this a transfer from another hospital?

Yes

No

Unknown

192. What was the date and time of transfer?

Date and time DD / MM / YYYY HH : MM AM/PM

193. What was the grade of the staff member accompanying the woman during transfer?

Consultant Anesthetist

Senior nurse

Registrar/RMO Anesthetist

Junior nurse

Other doctor

Other (please specify)

194. Length of stay in the unit before death

Days and hours

195. Please provide a summary of the circumstances surrounding this woman's death?

**196. What do you think can be learnt from this case?
Has it changed your individual practice?**

PART B - Section 5 Deaths Related to Psychosocial Morbidity

To be completed by the Psychiatrist, GP, Community Psychiatric Team and any other health professionals involved in this woman's care.

Each agency involved in caring for the woman should complete a separate report and attach to this form.

Please also attach a copy of suicide report and details of last psychiatric assessment.

197. Did this woman have a history of any pre-existing (to this pregnancy) psychiatric illness? if yes, please provide details

Yes No Unknown

Please provide details under the following headings: Diagnosis; Co-morbid personality issues; Past treatment; Medication; Details of therapy; Details of any admissions to a psychiatric unit

198. Did this woman have a history of substance misuse?

Yes No Unknown

199. Was this woman asked about substance misuse

During her pregnancy Both Unknown
 In the post natal period Neither

200. Was there a first recognized onset of psychiatric morbidity associated with this pregnancy (including during the post natal period)? If yes, please give further details

- Yes No Unknown

Please provide details

201. Did this woman have a family history of psychiatric illness?

- Yes No Unknown

202. What was the highest level of psychiatric care that this woman received during this episode?

- None Outpatient Psychiatric care Substance Misuse Service
 Inpatient: Mother and Baby unit Community Psychiatric Team GP
 Inpatient: General Psychiatric Unit Counselling/Psychologist Unknown

203. Did the woman deliberately self harm before this pregnancy?

- Yes - Life threatening No
 Yes - Not life threatening Unknown

204. Did the woman deliberately self harm during this pregnancy?

- Yes - Life threatening No
 Yes - Not life threatening Unknown

205. Did the woman deliberately self harm after this pregnancy?

- Yes - Life threatening No
 Yes - Not life threatening Unknown

206. Was there communication between maternity and psychiatric services?

- Yes No Unknown

Please provide further comment

207. Were there delays in referral to psychiatric services?

- Yes No Unknown

Please provide further comment

208. Was there delays in the uptake/transfer of care by Psychiatric services?

- Yes No Unknown

209. Was psychiatric treatment commenced at any time during pregnancy or the post natal period?

- Yes No Unknown

210. If this was a suicide, what was the method used?

- Self poisoning/overdose Suffocation Firearms
 Carbon monoxide poisoning Jumping from a height Electrocutation
 Jumping/lying before a train Drowning Cutting or stabbing
 Hanging/strangulation Burning Unknown

Other (please specify)

211. Please provide a summary of the circumstances surrounding this woman's death Please discuss stressors; supports; contact with community services; domestic violence etc.

**212. What do you think can be learnt from this case?
has it changed your individual practice?**

PART C - Section 1 To be completed by the State and Territory Maternal Mort...

213. Primary cause of death (as specified by state and territory maternal mortality committee)

214. Classification of death

- Direct Late Unknown
 Indirect Unclassified

215. Was this death following transfer from another country of a non resident of Australia for medical assistance?

- Yes No Unknown

If yes, please give further detail

216. What was the source of the death notification

- Doctor Media Data linkage
 Midwife Word of mouth Unknown
 Coroner Search of hospital data collections

Other (please specify)

217. Was there enough information available at jurisdictional review to come to a conclusion surrounding the circumstances of death in this case?

- Yes No Unable to answer

218. If the death occurred in hospital, has a Root Cause Analysis (RCA) been undertaken?

- Not applicable Yes No Unknown

219. Was the death identified and reported as a sentinel event?

- Yes No Unknown

220. Please provide a brief summary of the circumstances surrounding this death and the Committee's conclusions