CODE FOR CASE ☐☐ ☐☐ ☐☐☐☐ MDE Office Use Only

Confidential Maternal Death Enquiry Ireland

Rapid report and surveillance form

Instructions

1. Fill in the form using the information available in the woman's maternity or general case notes.
2. Tick the boxes as appropriate. If you require any additional space to answer a question please use the space provided in section 7.
3. Please complete all dates in the format DD/MM/YY, and all times using the 24hr clock e.g. 18:37
4. **Codes and examples, indicated by the asterisk symbol *, are required in some answers. A list (not exhaustive) of codes and examples are included on the page 10 of the form.**
5. ***If you do not know the answers to some questions, please indicate this in section 7.***
6. If you encounter any problems with completing the form please contact the MDE Office or use the space in section 7 to describe the problem.

Please return this completed form to:

Coordinator
Maternal Death Enquiry (MDE), Ireland
5th floor, Cork University Maternity Hospital
Wilton, Cork
Tel:0214205053

Section 1: Woman's details

Maternal Age =

1.1 Ethnic group:[1*] *(enter code, please see final page for guidance)* ..... ☐☐ Not known ☐

1.2 Was this woman born in the Ireland? ..... Yes ☐ No ☐

If No, Country of birth: _____

1.3 Was this woman an Irish citizen? ..... Yes ☐ No ☐

If No, State country of citizenship: _____

State how long in Ireland before death:

If <24 months, number of months ☐☐

If ≥24 months, number of years ☐☐

Not known ☐

and please tick one of the following:

EU citizen ☐ Refugee / asylum seeker ☐ Recently arrived new wife of Irish citizen ☐

Tourist/short-term visitor ☐ Known "health tourist" ☐ Other ☐ Not known ☐

1.4 Did the woman speak/understand English? ..... Yes ☐ No ☐

1.5 Living arrangements: (Select one only)

Living with partner ☐ Living with partner and extended family ☐ Living alone ☐

Living with parent or extended family ☐ Other ☐ Not known ☐

1.6 What was the woman's employment status at booking?

Employed or self-employed *full or part-time)* ☐ Unemployed (*Looking for work)* ☐

Retired ☐ Student *(full or part-time)* ☐ Looking after home/family ☐

Permanently sick/disabled ☐ Not known ☐

1.7 Did the woman have a partner? ..... Yes ☐ No ☐

If Yes, what was the partner's employment status at booking?

Employed or self-employed *full or part-time)* ☐ Unemployed (*Looking for work)* ☐

Retired ☐ Student *(full or part-time)* ☐ Looking after home/family ☐

Permanently sick/disabled ☐ Not known ☐

1.8 Height at booking: ..... ☐☐☐ *cm* Not known ☐

1.9 Weight at booking: ..... ☐☐☐.☐ *kg* Not known ☐

1.10 BMI at booking: *(if height and weight not available* ..... ☐☐.☐

1.11 Smoking status:

Never ☐ Current ☐ Gave up prior to pregnancy ☐

Gave up during to pregnancy ☐ Not currently smoking but history unknown ☐

Not known ☐

1.12 Vaping status:

Never ☐ Current ☐ Gave up prior to pregnancy ☐

Gave up during to pregnancy ☐ Not currently vaping but history unknown ☐

Not known ☐

1.13 Was this woman known to misuse alcohol or other substances?

Yes ☐ No ☐ Not known ☐

1.14 Domestic Abuse:

Did this woman experience domestic abuse prior to pregnancy?

Yes ☐ No ☐ Not known ☐ Not documented ☐

Was domestic abuse **FIRST** identified during pregnancy?

Yes ☐ No ☐ Not known ☐ Not documented ☐

Was the woman asked about domestic abuse during her antenatal visits?

Yes ☐ No ☐ Not known ☐ No antenatal visits ☐ Not documented ☐

Was there a history of sexual or violent abuse to the woman when she was a child?

Yes ☐ No ☐ Not known ☐ Not documented ☐

1.15 Social Services involvement?

Did the woman have social services involvement during or after her pregnancy?

Yes ☐ No ☐ Not known ☐

If Yes, was this for own protection, child's protection, or both?

Own ☐ Child's ☐ Both ☐ Not documented ☐

Was the newborn infant taken or to be taken into care?

Yes ☐ No ☐ Not known ☐

Was the woman a care leaver? Yes ☐ No ☐ Not known ☐

1.16 Was this woman charged for any of the following care?

Charged for any antenatal care Yes ☐ No ☐ Not known ☐

Charged for any intrapartum care Yes ☐ No ☐ Not known ☐

Charged for any postnatal care Yes ☐ No ☐ Not known ☐

Charged for any other hospital care after the end of her pregnancy

Yes ☐ No ☐ Not known ☐

Section 2: Previous Obstetric History

2.1 Did the woman have any previous pregnancies? ..... Yes ☐ No ☐ Not known ☐

If No previous pregnancies, *please go to* ***Section 3***

2.2 Is the previous pregnancy history known? ..... Yes ☐ No ☐

If No, *please go to* ***Section 3***

2.3 Previous Pregnancies:

Number of pregnancies under 23 weeks ☐☐

Number of pregnancies beyond 23 weeks ☐☐

Enter counts only for completed pregnancies beyond 23 weeks

Number of *live* births ☐☐

Number of *still* births ☐☐

Number of caesarean sections ☐☐

2.2 Did the woman have any previous pregnancy problems?..... Yes ☐ No ☐

If Yes, please specify details:

Section 3: Previous Medical History

3.1 Did the woman have any pre-existing medical problems?[3*]

Yes ☐ No ☐ Not known ☐

If Yes, please specify details:

3.2*a* **Had this woman ever had mental health diagnosis?** Yes ☐ No ☐ Not known ☐

If No, *please skip 3.2b and go straight to* ***Section 3.3***

If Yes, please specify details:

3.2 *b* **Was she receiving treatment for mental health issues in the 12 months prior to, during, or after pregnancy?** ..... Yes ☐ No ☐ Not known ☐

If Yes, please specify details:

3.3 **Did this woman have a known learning difficulty?**..... Yes ☐ No ☐ Not known ☐

If Yes, please specify details:

Section 4: This Pregnancy

4.1 **Final Estimated Date of Delivery (EDD)[4*]**..... D D / M M / Y Y Not known ☐

Or Estimated gestation at date of death (in weeks)

Less than 20 weeks ☐ 20 weeks or more ☐ Not known ☐

4.2 **Was this known to be a multiple pregnancy?**..... Yes ☐ No ☐

If Yes, please specify number of fetuses: ☐

4.3 **Was this pregnancy known to be the result of assisted reproduction/IVF?**

Yes ☐ No ☐

4.4 Were there problems in this pregnancy? ..... Yes ☐ No ☐ Not known ☐

If Yes, please specify details:

4.5 Did the woman receive antenatal care? ..... Yes ☐ No ☐

4.6 Was the woman booked for antenatal care? ..... Yes ☐ No ☐

If Yes, what was the date of her first booking visit? D D / M M / Y Y

4.7 What was the elected place of delivery? ..... Home ☐ Other ☐ Not known ☐

Hospital—Midwifery Unit ☐ Hospital—Consultant Unit ☐

Hospital—Unit unknown ☐ Birthing Centre ☐ Private Hospital ☐

4.6 Did the woman have any antenatal visits? ..... Yes ☐ No ☐

If Yes, what was the total number of antenatal visits attended? ☐☐

What was the total number of missed antenatal visits? ☐☐

Section 5: Delivery

5.1 Was the woman undelivered at the time to death? ..... Yes ☐ No ☐

If No, where did she deliver? Ambulance/A&E ☐ Home ☐ Birthing Centre ☐

Hospital—Midwifery Unit ☐ Hospital—Consultant Unit ☐

Hospital—Unit unknown ☐ Private Hospital ☐ Hospital (other) ☐

Other ☐ Not known ☐

5.2 Was this delivery an early pregnancy loss (up to and including 20 weeks)?

Yes ☐ No ☐ Not known ☐

If Yes, please state if loss was due to:

Ectopic ☐ Miscarriage ☐ Termination of pregnancy ☐ Other ☐

If Other, please specify: _____

What was the date of the pregnancy loss? D D / M M / Y Y

If Yes to 5.1 or 5.2, *please complete* ***Section 6a, 7 and 8***

5.3 Was delivery induced? ..... Yes ☐ No ☐

5.4 Did the woman labour? ..... Yes ☐ No ☐

5.5 Was delivery by caesarean section? ..... Yes ☐ No ☐

If Yes, please state:

Grade of Urgency[5*] ☐☐

Indication for caesarean section _____

5.5 Did the woman ever have anaesthesia? ..... Yes ☐ No ☐

If Yes, what method(s) were used?

GA ☐ Epidural ☐ Spinal ☐ Combined epidural/spinal ☐ Not known ☐

Section 6: Outcomes

Section 6a: Woman

6a.1 Was the woman admitted to critical care (level 3)? ..... Yes ☐ No ☐

6a.2 Did any other major morbidity occur that was not described on the death certificate?

Yes ☐ No ☐

If Yes, please specify details: _____

6a.3 Was the woman discharged from hospital after delivery and before death?

Yes ☐ No ☐ Never in hospital ☐

6a.4 What was the date and time of death? ..... D D / M M / Y Y h h : m m

OR tick if time not known ☐

What was the initially presumed cause of death?

_____

Was a post mortem examination undertaken?

Hospital ☐ Coroner/Procurator Fiscal ☐ No ☐ Not known ☐

What were the causes of death as stated on:

PM ☐ Death Certificate ☐

I(a) _____

I(b) _____

I(c) _____

II _____

6a.5 Where did the woman die? .....

Ambulance/A&E ☐ Birthing Centre ☐ Critical care ☐

Hospital—Midwifery Unit ☐ Hospital—Consultant Unit ☐

Hospital—Unit unknown ☐ Private Hospital ☐

Hospice ☐ Hospital other ☐ Home ☐ Other ☐ Not known ☐

Section 6b: Infant 1

6b.1 What was the date and time of birth? ..... D D / M M / Y Y h h : m m

OR tick if time not known ☐

6b.2 Mode of delivery:

Spontaneous vaginal ☐ Ventouse ☐ Forceps ☐ Vaginal Breech ☐

Pre-labour caesarean section ☐ Caesarean section after onset of labour ☐

Peri-mortem caesarean section / Resuscitative hysterostomy ☐ Not known ☐

6b.3 Birthweight: ..... ☐☐☐☐ *g*

6b.4 Sex: ..... Male ☐ Female ☐ Indeterminate ☐ Not known ☐

6b.5 Was the infant stillborn? ..... Yes ☐ No ☐

If Yes, *please go to* ***Section 7***

6b.6 Was the infant diagnosed with HIE/neonatal encephalopathy? ..... Yes ☐ No ☐

6b.7 Was the infant admitted to the neonatal unit? ..... Yes ☐ No ☐

6b.8 Did any other major complications occur?[7*] ..... Yes ☐ No ☐

If Yes, please specify: _____

6b.9 Did this infant die? ..... Yes ☐ No ☐

If Yes, please specify date of death: D D / M M / Y Y

What were the causes of death as stated on the death certificate:

I(a) _____

I(b) _____

I(c) _____

II _____

** for guidance please see final page*

Section 7: Please use this space to enter any other information

Section 8: Detail's of person completing form

8.1 **Signature:** _____

8.1 **Print Name:** _____

8.1 **Job title:** _____

8.1 **Date:** ..... D D / M M / Y Y

Thank you for your time, your input is extremely valuable!

Local clinician information

We require that a confidential Local Report form be completed by a clinician on behalf of each of the groups listed in the table below. Please could you tell us the name and contact address of the most appropriate person for us to contact to provide this assessment. If you feel that a particular group is not applicable to this case please specify clearly on the form "No involvement"

	Full name (Include title)	Job title	Address
Obstetric consultant in charge of care			
Senior midwife			
Anaesthetic consultant in charge of care			
Critical care consultant in charge of care			
General Practitioner			
Emergency medicine consultant in charge of care			
Physician e.g. Consultant cardiologist, Haematologist			
Consultant psychiatrist in charge of care			

Definitions

1. UK Census Coding for ethnic group

WHITE

01. British/English/Welsh/Scottish/Northern Irish
02. Irish
03. Gypsy or Irish traveler
04. Any other white background

MIXED

05. White and black Caribbean
06. White and black African
07. White and Asian
08. Any other mixed background/multiple ethnic background

ASIAN OR ASIAN BRITISH

09. Indian
10. Pakistani
11. Bangladeshi
12. Chinese
13. Any other Asian background

BLACK OR BLACK BRITISH

14. Caribbean
15. African
16. Any other black background

OTHER ETHNIC GROUP

17. Arab
18. Any other ethnic group

2. Previous or current pregnancy problems, including:

Thrombotic event
Amniotic fluid embolism
Pre/Eclampsia
3 or more miscarriages
Preterm birth or mid trimester loss
Haemorrhage
Placenta praevia
Gestational diabetes
Significant placental abruption
Post-partum haemorrhage requiring transfusion
Puerperal psychosis
Significant postnatal depression
Suicide attempt
Neonatal death
Stillbirth
Baby with a major congenital abnormality
Small for gestational age (SGA) infant
Large for gestational age (LGA) infant
Infant requiring intensive care
Surgical procedure in pregnancy
Hyperemesis requiring admission
Dehydration requiring admission
Ovarian hyperstimulation syndrome
Severe infection e.g. pyelonephritis

3. Previous or pre-existing maternal medical problems, including:

Cardiac disease
Essential Hypertension (not pregnancy related)
Renal disease
Neurological disorders
Endocrine disorders
Haematological disorders
Autoimmune diseases:
Gastrointestinal disease
Cancer
Infectious disease (e.g. HIV,TB) Psychiatric disorders

4. Estimated date of delivery (EDD): Use the best estimate (ultrasound scan or date of last menstrual period) based on a 40 week gestation

5. RCA/RCOG/CEMACH/CNST Classification for urgency of caesarean section:

1. Immediate threat to life of woman or fetus
2. Maternal or fetal compromise which is not immediately life-threatening
3. Needing early delivery but no maternal or fetal compromise
4. At a time to suit the woman and maternity team

6. Major maternal medical complications, including:

Persistent vegetative state
Cardiac arrest
Cerebrovascular accident
Adult respiratory distress syndrome
Disseminated intravascular coagulopathy
HELLP
Pulmonary oedema
Mendleson's syndrome
Renal failure
Thrombotic event
Septicaemia
Required ventilation

7. Fetal/infant complications, including:

Respiratory distress syndrome
Intraventricular haemorrhage
Necrotising enterocolitis Neonatal encephalopathy
Chronic lung disease
Severe jaundice requiring phototherapy
Congenital anomaly
Severe infection e.g. septicaemia, meningitis
Exchange transfusion