

**DEPARTMENT OF HEALTH
CONFIDENTIAL**

MATERNAL DEATH NOTIFICATION: ASSESSOR'S FORM

Department of Health Office case number										
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CAUSE OF DEATH (See Assessors Guidelines for codes)

	Codes		
Primary (underlying) cause of death: Specify:			
Final cause of death: Specify:			
Contributory (or antecedent) cause/s: Specify:			

AVOIDABLE FACTORS, MISSED OPPORTUNITIES AND SUBSTANDARD CARE

1. PATIENT ORIENTATED

<i>Personal problems:</i> <i>Family problems:</i> <i>Community problems:</i>
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2. ADMINISTRATIVE/HEALTH SYSTEM FAILURE

<i>Transport problems:</i> <i>Barriers to entry to Hospital or clinic:</i> <i>Lack of accessibility:</i> <i>Lack of health care facilities:</i> <i>Lack of personnel:</i> <i>Lack of appropriately trained staff:</i> <i>Communication problems:</i>
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3. MEDICAL CARE

<i>Problems with routine antenatal care:</i>
<i>Problems with routine intrapartum care:</i>
<i>Problems with routine postpartum care:</i>
<i>Problems with emergency event (specify the period of pregnancy in which the emergency occurred):</i> <div style="text-align: center; margin-left: 100px;"> <i>Early pregnancy Antenatal Intrapartum Postpartum</i> </div> <i>Initial assessment:</i> <i>Problem identification/diagnosis:</i> <i>Management plan:</i> <i>Continued monitoring:</i>
<i>Problems with resuscitation:</i>
<i>Problems with anaesthesia (if applicable):</i>
<i>Unprofessional conduct:</i>

4. COMMENTS AND BRIEF SUMMARY OF YOUR OPINION ON CASE

Date received							Assessor 1:	Assessor 2:
Date returned							Signature:	Signature:
	D	D	m	m	y	y