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எனது இல ) FHB/MMMS/INDR/2021  
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Your No. : )

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திகதி ) 11 / 02 / 2021  
Date )

All Provincial Directors of Health Services

All Regional Directors of Health Services

All Heads of Hospitals / Private Sector Hospitals

### **Strengthening of the Institutional Maternal Death Reviews**

Maternal Death Surveillance and Response (MDSR) process, as a unique modality, has been operational resulting in improvements in maternal care service delivery and gradual reduction of maternal mortality to a lower level over the past four decades.

Institutional and field level maternal death investigations are crucial elements in MDSR process that have largely contributed to the identification of service gaps and early interventions to rectify them. The need for strengthening of the Institutional Maternal Death Reviews (IMDR) has been emphasized at many forums including the National Maternal Mortality reviews and also at several stakeholder meetings held with the higher authorities of the Ministry of health.

You are emphasized on the following with regard to conducting a quality Institutional Maternal Death Reviews at hospital/s under your purview;

1. Head of the institution should establish a mechanism to receive an intimation of a probable maternal death immediately from all relevant units of the hospital.  
(Refer to maternal death notification criteria overleaf)
2. The notification of the maternal deaths to Director FHB and relevant RDHS should be done within 24 hours of the occurrence via fax, email, SMS or by a telephone call (0112692745).  
(Refer Circular No: General Circular 1695/26.03,1991 and guidelines published on [www.fhb.lk](http://www.fhb.lk))
3. The Bed Head Ticket (BHT) and other clinical records should immediately be taken into the custody of the head of the hospital. No alteration of the notes should be allowed to any category of the staff.
4. Head of the institution should organize the Institutional Maternal Death Review within 14 days of the occurrence of the index death in consultation with the Director/ Family Health Bureau to facilitate the participation of representatives from the Ministry of Health and other relevant experts from the national level.
5. Mandatory Participation should be ensured of all categories of staff who were involved in the management of the index case, other relevant clinicians (Other Obstetricians / Anesthetists / Physicians / Forensic Pathologists / Transfusion Specialists etc) and any other relevant health official considered to be important by the head of the institution, is. A written communication by name of the relevant healthcare official should be sent under the signature of the head of the hospital

6. All participants of the Institutional Maternal Death Review should sign a confidentiality agreement prior to the meeting.  
(Refer to the template attached)

You are instructed to implement the above regulations and ensure that all relevant officials adhere to the same.



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Director General of Health Services

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Director (MCH / MS / TCS / Primary Care / Private Sector)  
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# Maternal Mortality Reviews

*(Institution / Field / District / National)*

## Confidentiality Agreement for Participants & Presenters

Maternal mortality review meetings are conducted as a no-fault finding endeavor to learn lessons out of service deficiencies in caring for pregnant women.

These mechanisms provide different stakeholders of maternal & child health opportunity to:

- Critically analyze the circumstances that surrounded an outcome;
- Recommend process improvement;
- Initiate the appropriate action for process improvement; and
- Oversee progress.

During your participation in the Institution / Field / District / National infant mortality review meeting you are required to maintain strict confidentiality regarding individual service performance and case presentation information.

Presenters and Participants should not divulge specific details of clients or healthcare workers in a way they could be identified personally.

The individual:

1. Must act honestly, in good faith and maintain confidentiality of client, healthcare workers or service provider (institute) information
2. May not record review discussion.
3. Has a duty to use due care and diligence not to disclose information presented at the review meeting.
4. Must not discuss or make improper use of information acquired outside the review meeting.
5. Must not allow personal interests, or the interests of any associated person, to conflict with the interests of the purpose of the review meeting
6. Should not engage in conduct likely to bring discredit on the client, healthcare workers or individual health service/s.
7. Has an obligation, at all times, not only to comply with the letter of this agreement, but also to have regard to the spirit of the principles underlying it.
8. Recognizes that all people have the right to be treated fairly and with respect at all times.

By signing this agreement you are acknowledging that you have read and understand this statement and agree to maintain the strictest confidentiality about the individual case presentations and service performance details to which you are exposed.



# Institutional Maternal Death Notification Criteria

## Maternal Death Surveillance at Institutional Level

- Once a maternal death occurs in an institution (Government or private hospital), the Head of the institution should take the custody of the bed head ticket (BHT) and all the documentation of management details of the deceased mother. All the pages should be

numbered and the original document should be made available for relevant officers / review

meetings for investigation procedure. The BHT should not be reproduced. BHT should not be taken out of the office of the Head of the Institution and extraction of information from the BHT should be done within the office premises only.

- A copy of the BHT and other relevant documents related to the management of the index case should be sent to Family Health Bureau when requested.

- It is compulsory to conduct a post mortem in all cases of maternal deaths as per the circular issued by the Secretary to the Ministry of Justice and Law reforms dated 2008.10.02 to all coroners and letter issued by director general of health services (DGHS) on 2011.01.12.

- A representative (VOG / VP or Registrar / SHO) from the relevant unit of the hospital should participate at the post-mortem examination. Relevant JMO should inform the index unit the time of the post-mortem examination through the head of the institute.

- A copy of the post mortem report should be issued by JMO to DGHS, Director – FHB and Head of the hospital where maternal death occurred

## Notification procedure of maternal deaths to be followed at institutional level

- Immediately after the occurrence of a death which fulfils above notification criteria (2.1)

the relevant staff should report it to the head of the institution.

- JMO should also notify such deaths to the head of the institution after the post mortem.

officers; • Head of the Institution (Director/MS/DMO/MO-IC) as the team leader

- Consultant Obstetrician and Gynaecologist or the relevant Specialist of the hospital unit in which the death occurred (acting consultant in his/her absence) and all other relevant consultants who managed the mother (Physician, Surgeon, Anaesthetist, Psychiatrist etc)

- Medical officer/s who attended the deceased mother (DMO, MO/IC, senior house officer, house officer etc.)

- Judicial Medical Officer

- Medical officer – blood bank – when relevant

- Grade I Nursing Officer /Nursing Officer In Charge of the ward/ labour room - when relevant

- Head of the Institution of hospitals where the patient was managed before transfer

- Medical Officers Maternal and Child Health (of the districts where the mother is resident and where the hospital is situated)

- Medical Officer of Health from the mother's area of residence

- Public Health Midwife from the mother's area of residence

- The institutional investigation should be coordinated by the medical officer (preventive health) on behalf of the head of the institution.

### **Immediate Response to identified service deficiencies:**

- The Head of the Institution is responsible for the immediate implementation of the corrective actions within the hospital without delay as decided at the institutional review.

Please include all the actions taken in the H677.

- Coroners should also be requested to notify such deaths to the RDHS and the head of the institution after inquiry into sudden deaths.

- The head of the institution will then notify the death within 24 hours by telephone, telegram, fax or email to the following officers;

Director – MCH (Family Health Bureau) Tel/Fax: 0112692745

PDHS and RDHS (where the institution located)

PDHS and RDHS (deceased residence)

MOH (deceased residence)

Head/s of the previously managed institution/s

- A sample format of Intimation of Maternal Deaths can be downloaded from the FHB website: [www.familyhealth.gov.lk/](http://www.familyhealth.gov.lk/) under submenu "Forms".

- Whenever the death of such a mother transferred from another institution occurs, the receiving institution should notify the head of the previously managed institution of the death.

## **Institutional Investigation procedure of a maternal death**

(Government and private hospitals)

- Separate institutional investigations should be performed by each institution involved in the management of the deceased mother.

- The investigation should be conducted within 14 days of occurrence of a maternal death as this would enable to identify precisely the circumstances that led to the death with fresh information. The circumstances of the death should be discussed in detail with the intention of identifying preventive measures.

- The institutional investigation is the responsibility of the Head of the Institution.

- Investigation should be carried out as a team which should comprise of the following

## Reporting the institutional investigation

- The information obtained during the investigation should be entered in form H 677 in triplicate. A copy of the latest version of H677 should be obtained from the MOMCH or downloaded from the FHB website: [www.familyhealth.gov.lk/](http://www.familyhealth.gov.lk/) under submenu "Forms".
- Consultant Obstetrician and Gynaecologist or the relevant Specialist of the hospital unit in which the death occurred and Head of the Institution should ensure the completeness of the format.
- The completed format (H 677) should be sent to the following institutions within 14 days of occurrence of the maternal death.
- Head of the institution should also ensure that these deaths are reported through H830 (Monthly Report on Maternal Statistics) and Quarterly Indoor Morbidity and Mortality Returns sent to the relevant sectors. Also he/she should ensure that pregnancy and/or childbirth should be mentioned as an underlying cause of death when the death declaration is given.