REVISED GUIDELINES - MATERNAL DEATH AUDIT

Maternal Mortality Rate of the State of Tamil Nadu is 97/100,000 Live births. (SRS-2008). Target suggested by the Government of India and State Government for the 12th Five Year Plan period is 41/100,000 Live births at the end of 2017.

In the State, Community based MDR is ongoing since 2004. District Level Maternal Death Audit Committee with the District Collector as the chairperson is conducting monthly meetings on maternal deaths and the relatives of the deceased attend the meetings.

Facility Based MDR is ongoing since 2010 through video conference and Government MCH/DH/SDH maternal deaths are being reviewed on the last Thursday of every month.

A proposal to intensify MDR so as to include all Maternal deaths in the State has been approved by NPCC of NRHM in the PIP 2012-13.

Hence it is proposed to form a panel of Experts at each HUD to undertake the inquiry of each Maternal death occurring anywhere in the HUD (Govt. Institution / Private Institution / Home) within 48 hours of Maternal death and send a detailed report to the SHS along with specific remarks.

**Given below are the guidelines:**

1. DDHS will identify a panel of Experts consisting of renowned obstetricians and anesthetists in and around the district:
   
   Timeline: 7 days from the receipt of this letter

2. Deputy Director of Health Services will sensitise all the Institutions (Govt. / Private) / IMA/FOGSI/etc. about the proposed special MD audit and enlist their fullest cooperation.
   
   Timeline: 10 days from the receipt of this letter

3. The panel of specialists may include both Govt. (in service / retired) and Private Doctors. They may be, preferably, not below the rank of CCS / Professor of the speciality or equivalent.

4. The specialists have to be willing to travel across the district, if need be, and submit a detailed report (in triplicate – 1 to SHS, 1 to District Collector & 1 to
Deputy Director of Health Services) on the chain of events from AN registration leading to the death of the PW within 5 days of occurrence of MD.

5. The specialists have to be chosen from the institutions other than the institution where the MD occurred.

6. The expenditure towards the conduct of enquiry will be paid as follows:

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Activity</th>
<th>Amount in Rs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Honorarium for the Experts of the team</td>
<td>8000/-</td>
</tr>
<tr>
<td></td>
<td>Rs.2000 per day x 2 days x 2 Experts</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Fuel expenses</td>
<td>1000/-</td>
</tr>
<tr>
<td></td>
<td>Rs.500 per day x 2 days</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>* Incidental expenses</td>
<td>1000/-</td>
</tr>
<tr>
<td></td>
<td>Rs.500 per day x 2 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>10000/-</td>
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</tbody>
</table>

* Incidental expenses to be incurred are for food and refreshments of the team, towards stationeries for preparation of reports and expenditure towards Xeroxing the needed documents.

**MD Special Audit:**

1. DDHS will have to be notified at once by the duty Medical Officer (both private and Govt.) on the admission of critically ill pregnant woman / when the admitted pregnant woman or delivered mother becomes critical or dead. A delay of more than 15 minutes after declaration of death may amount to negligence of duty / responsibility of the Institution.

2. DDHS will immediately alert the panel of experts and based on availability, will ensure that along with him, a team of 2 specialists visit the Institution (at which the death has occurred) at the earliest.

3. The team will undertaken visits to the place(s) from where referral was made (if the deceased mother is a referred case), Facility / facilities where AN registration and AN check-ups were undertaken (MCH/DH/SDH/PHC/HSC/Urban Health Institutions / Private Institution / Any other) in and around the district and upto the house-hold level based on the merit of the case.

4. All data pertaining to the deceased mother have to be presented to the MD audit team at the time of visit by all the Institutions (including private Hospitals) involved in the management of the deceased mother from AN-registration till Maternal Death.

5. The Team will scrutinise the reports and case-sheets pertaining to the deceased mother and arrive at the plan of investigation and undertake them.
6. The Team may prepare a report of the Maternal Death, with Xeroxed copy of details of AN registration, AN care, case-sheets, investigation reports (wherever applicable) in triplicate and send one copy to the State Health Society within 5 days of occurrence of Maternal Death.

7. The report has to present all the medical / social / economic causes and specify the areas of system failure if any in the occurrence of maternal death investigated by them.

8. The Experts shall suggest measures to prevent occurrence of such Maternal Deaths in future.

9. DDHS will disseminate the steps to be taken to address the preventable causes of maternal deaths in the monthly coordination meetings and facilitate their implementation in all the institutions of the HUD.

Sd./..PANKAJ KUMAR BANSAL, 
MISSION DIRECTOR.