Ministry of Health

Hospital Case Review Format for Under - 5 Child Deaths

[For all under 5 child deaths including all neonatal & infant deaths]

HS-3

Hospital Name: Ward / Unit of Death:			**Neonatal Death** ☐	**Post-Neonatal Infant Death** ☐	**Child Death (1 – 4 years)** ☐
A	**Basic Information**				
1	Name of Infant/Child		**8**	MOH Area	
2	Sex of Infant/Child	*Male / Female / Ambiguous*	**9**	RDHS Area	
3	Ethnicity	*Sinhalese / Tamil / Muslim / Other*	**10**	Date of death	DD /MM / YYYY
4	Residential Address		**11**	Date of Birth	DD /MM / YYYY
5	Name of Mother		**12**	Age at death	_____ *Days* _____ *Hours*
6	NIC No of Mother		**13**	BHT No:	
7	Age of mother	_____ Years	**14**	Place of death	*On admission / Ward / SCBU / ICU*

B	**Short History** *(from the onset of the illness up to death)**	
	Post mortem / Necropsy Findings	
	Pathological / Forensic Record No:_____	*Done* ☐ *Not done* ☐ *Please give details:* *Please give reasons if a post-mortem was NOT conducted.*

*Please indicate chronology of events with details about onset of illness, Symptoms, consultations, investigations done, treatment / management done both at outpatient & inward levels

D	**Cause/s of Death**	
1	Immediate Cause of Death	
2	Underlying Cause/s of Death	1. 2. 3.
3	Contributory / Other causes of death	

E	**For Neonatal Deaths – ICD PM Classification**		
	E1 - ICD-PM Group *The group of main disease or condition that led to death in neonate*	**E2 - Broad ICD-PM Cause**	**E3 - ICD specific category**
	N1_Congenital_malformations_and _chromosomal_abnormalities **N2**_Disorders_related_to_fetal_growth **N3**_Birth_trauma **N4**_Complications_of_intrapatum_events **N5**_Convulsions_and_disorders_of_cerebral_status **N6**_Infection **N7**_Respiratory_&_cardiovasular_disorders **N8**_Other_neonatal_conditions **N9**_Low_birth_weight_and_prematurity **N10**_Miscellaneous **N11**_Neonatal_death_of_unspecified_cause Unable_to_classify	*The broad cause of death selected from Broad ICD codes. (Please refer to guidelines & codes)*	Specific cause/s of death

	E4 - ICD -PM Group (Main maternal disease or condition affecting Neonate)	E5 - ICD -PM specific group *(Specific maternal condition/s affecting Neonate)*
	***M1**_Complications_of_placenta_cord_and_membranes* ***M2**_Maternal_complications_of_pregnancy* ***M3**_Other_complications_of_labour_and_delivery* ***M4**_Maternal_medical_and_surgical_conditions* ***M5**_No_maternal_condition*	
F	Death Registration Information	
	1. Declaration of Death (B 33) filled? Yes / No	2. Declaration of Death (B 33) Number & Date:

Detailed Case Abstraction

G	**Birth History** *(For all Neonatal Deaths and for other deaths If relevant)*		
1	Parity:		
2	Were there any **maternal diseases** diagnosed prior to pregnancy OR other risk conditions identified during pregnancy contributed to the illness of the diseased infant/child ? *(If 'Yes' , please give details)*		
3	Type of Pregnancy	*Singleton / Twin / Multiple*	**4.** Date of Delivery / Birth: DD / MM / YYYY
5	Place of Delivery		**6.** Period of Gestation : ____ *Weeks* _____ *days*
7	Type of Delivery	*Normal Vaginal / Breech / Forceps / Vacuum / Elective CS / Emergency CS*	
8	Birth Weight	_____ *grams*	**9.** Birth attended by: Midwife / Nurse / HO / SHO / Registrar / VOG
10	Apgar score at delivery	5 minutes 10 minutes	**11.** Maturity at Birth: _____ wks. *(Add comments)*
12	Complications at birth / during neonatal period : **Yes** ☐ **No** ☐ *(If 'Yes', please give details)*		
13	Whether resuscitation needed at birth? ☐ Yes ☐ No If 'yes', resuscitated by a trained person ? ☐ Yes ☐ No Modes of resuscitation: ☐ Nasopharyngeal Suction ☐ Bag & Mask ☐ Oxygen ☐ Intubation ☐ Ventilation (☐ CPAP ☐ Other: _____) ☐ Other:_____		
14	Were there any reasons for special care (SCBU /ICU)? **Yes** ☐ **No** ☐ *(If 'Yes' , please give details)*		
15	**Medications** ☐ Surfactant ☐ Antibiotics: (☐ Oral ☐ IV) _____ ☐ IV Fluids:_____ ☐ Other:_____		
16	Kangaroo Mother Care ☐ Given ☐ Not given		
17	Breastfeeding ☐ Initiated within 1 hr. ☐ Later: ____		
18	Was the baby given formula milk ? **Yes** ☐ **No** ☐ *(If 'Yes' , please give reasons)*		
19	Details of the condition of the newborn on discharge including whether breastfeeding was established ;		
20	Any congenital abnormalities Infant / Child with Special Healthcare Needs ? **Yes** ☐ **No** ☐ *(If 'Yes' , please give details)*		

H	Details related to onset of illness & care received prior to the admission
1	Are there any identified or obvious deficiencies in the provision of care for the infant / child by the primary health care givers at field level (MOH / Public Health Midwife? **Yes** ☐ **No** ☐ **Not Relevant** ☐ *(If 'Yes' , please give details)*
2	Was there any delay in seeking medical care by the parents / guardian? **Yes** ☐ **No** ☐ **Not Relevant** ☐ If yes, please give the details & contributory factors;
3	Is it the continuation of care after delivery ? **Yes** ☐ **No** ☐ **Not Relevant** ☐
4	Did the index infant / child have clinical management at other Units / Hospitals/ Institutions /Private sector/ general practitioners prior to admitting to your unit / hospital? **Yes** ☐ **No** ☐ *(If 'Yes' , please give details)*
5	Any identified delays/deficiencies in receiving healthcare for this infant / child prior to the admission to your Unit;

I	Details of Hospital inward Management
1	Reason for admission
2	Referred to hospital by: *(Please tick ✓)* Self-referral by parents ☐ MOH ☐ PHM ☐ GP ☐ MO-OPD / MO Clinic ☐ Paediatrician ☐
3	If transferred to your hospital by another health institution, Name of the previous hospital the patient was managed:
4	Reason for transfer:
5	Date of admission to hospital: DD / MM / YYYY Time: OPD/PCU/Admission desk: ___:____ *am/pm* Ward:___:____ *am/pm*
6	**Presenting complaints and condition at the time of admission:***(Please indicate brief examination findings)*
7	**Past Medical Conditions & details:**
	8. Family History: **9. Consanguinity : Yes** ☐ **No** ☐
10	Whether the infant /child has received age appropriate **immunization**? **Yes** ☐ **No** ☐ *(If 'No', please give details)*
11	Weight: _____ grams
	12. Length /Height: _____ cm
	13. Temperature: _____ F°/C°
	14. Blood group & Rh:
15	Comment on the **nutritional status / growth**:
16	**Investigation** findings at the time of admission and immediately afterwards:
17	How long after admission was the infant/child attended by a Medical Officer? ____ *Minutes*
18	If there was undue delay in attending, please describe why:
19	Time taken for infant / child to receive the treatment ordered by the HO/MO after ordering? ____ *Minutes*

20	If there was undue delay in <u>receiving treatment</u>, please describe why:	
20	Categories of senior clinicians saw/attended to the sick baby:	Senior House Officer (SHO) / DMO ☐ Registrar / Senior Registrar ☐ Paediatrician ☐ Other ☐ (Please specify)……..
21	If none of the above categories did not see the infant / child, have their opinion been sought / obtained regarding the management? **Yes** ☐ **No** ☐ *(If 'No', please give details)*	
22	**Investigation findings throughout the management**	
	(Please use a separate sheet if necessary)	
23	**Problems /Complications detected and the details of management**	
	(Please use a separate sheet if necessary)	
24	Please describe the involvement of any **other specialists** (e.g. Surgeon / Cardiologist / Nephrologist /Anesthetist etc.). *If their involvement was significant please provide details of their actions:*	
25	Please describe the contribution of **under-nutrition** if any and any special nutritional management the patient received;	
J	View of the investigation team on factors contributing to infant / child death	
1	Any avoidable factors relating to seeking medical care or mother's /guardian's compliance :	
2	Difficulties in reaching the health facility: *(Communication / Transport / Ambulances):*	
3	Any avoidable factors identified at field health care (MOH / PHM):	
4	Any avoidable factors identified at the first health encounter by GP/MO-OPD:	
5	Any avoidable factors in the clinical management or deficiencies in attitude / negligence / judgment	

6	Lack of /non availability of health personnel:
7	Lack of /non availability of facilities and other logistics: *(eg. PBU /ICU/ Ventilators /OT /laboratory services/ Blood /Medications)*
8	Areas for improvement in hospital administration:
K	Overall view of the investigation team
1	Can you think of any steps/actions, which if taken earlier, might have prevented this death?
2	If you were treating this case again what changes would you make that will help to avoid such deaths?
3	What else would you recommend for avoiding infant/child deaths in similar circumstances at first contact level/clinicians/field staff/administrators?
4	**Preventability:** Preventable ☐ Unpreventable ☐ Inconclusive ☐ *Remarks:*
L	Lessons learnt & actions taken
Describe the lessons learnt out of the index death & actions already taken to rectify the identified deficiencies.	

Date of infant / child death notification sent	DD / MM / YYYY	Date of hospital death review conducted	DD / MM / YYYY

M Names & Designations of the investigation team:			
Name	*Designation*	*Name*	*Designation*

Name of the Neonatologist / Paediatrician: Dr. _____ **Signature:** _____ **Date:** DD / MM/ YYYY

Name of Head of Institution: Dr. _____ **Signature:** _____ **Date:** DD / MM/ YYYY

Official Stamp:

Please prepare this report in triplicate and send one copy each to: ***Director / Family Health Bureau*** *and* ***Regional Director of Health Services (of mother's residence)****. Keep the remaining copy for official purposes at your institution.*
Data in this format should be entered to **National Hospital Under – 5 Child Death Register**: *https://erhmis.fhb.health.gov.lk/mmsbds/dhis-web-commons/security/login.action*