Annexure 12

VERBAL AUTOPSY FORM FOR INTERVIEWING FAMILY OF REPORTED AEFI

Mandatory for the cases where inadequate information is available regarding the cause and course of events leading to death *(brought dead/home death/ insufficient medical records/ not hospitalized/ clinical diagnosis not possible)

Namaskar/Greetings
We are from the District Health Office of …….. (Name of district). We have come to know about the death of (name)…… We would like to know from you in detail about the illness that led to this event.

You are requested to let us know about the illness, treatment received, any past medical conditions, pregnancy and delivery (for infants). This information is critical to get a clear picture for identifying the cause of the death which will assist in improving healthcare services in the district. For this reason, we would like to meet and interact with the person/family member who was present during the event. All the information collected from you/family members shall be kept as confidential.

EPID NO……../……. /…….
State: _____ District_____
Block: _____ PHC: _____
Name of the Child/Person: _____
Age (in days/months/years): Sex: Male/Female
In case of pregnant female, name of spouse: _____

Date of interview: DD/MM/YYY Time of interview: …/….. (AM/PM)
Place of interview: _____

Section 1. Basic Details

A) Patient identifiers

Name of the Child/Person: _____ _____ _____
Age (in days/months/years) : Sex: Male/Female
Date of Birth: DD/MM/YYYY

Family members	Name	Education	Occupation	Mobile no.
Father				
Mother				
Spouse (if married)				

Complete address with pin code:

_____

_____

Date & Time of death: _____

Place of death: Home/Government facility / Private facility / others, specify……
(Please tick)

B) Details of respondent and family members:

S No	Name of family members/ respondent	Age	Education	Relation with deceased
1				
2				
3				
4				
5				
6				

Name of the main respondent: _____
(Preferably one who had witnessed the event/was present with the deceased)

Could you tell me <child's name> illness that lead to death? (Record verbatim: narrative of the witness in his/her words):

C) Details of vaccines received one month prior to the onset of illness that led to death:

Vaccine name	Date	Time	Place	Route (oral/IM/SC/ ID)	Site (verify from mother)	Person who administered the vaccine (verify from mother)
Vaccine 1						
Vaccine 2						
Vaccine 3						
Vaccine 4						

- Verify vaccines received from the immunization card, if available and check with the AWC/Sub Centre/PHC/Private practitioner /other…..specify for the same.
- Immunization card available: Yes/No
- Vaccine information: Matching/ Not matching
  If not matching then specify_____

Fig-1: CHILD: Mark the injection site(s) of the vaccines given and location of any swelling/redness at or near injection site

Front Back Right side Left side

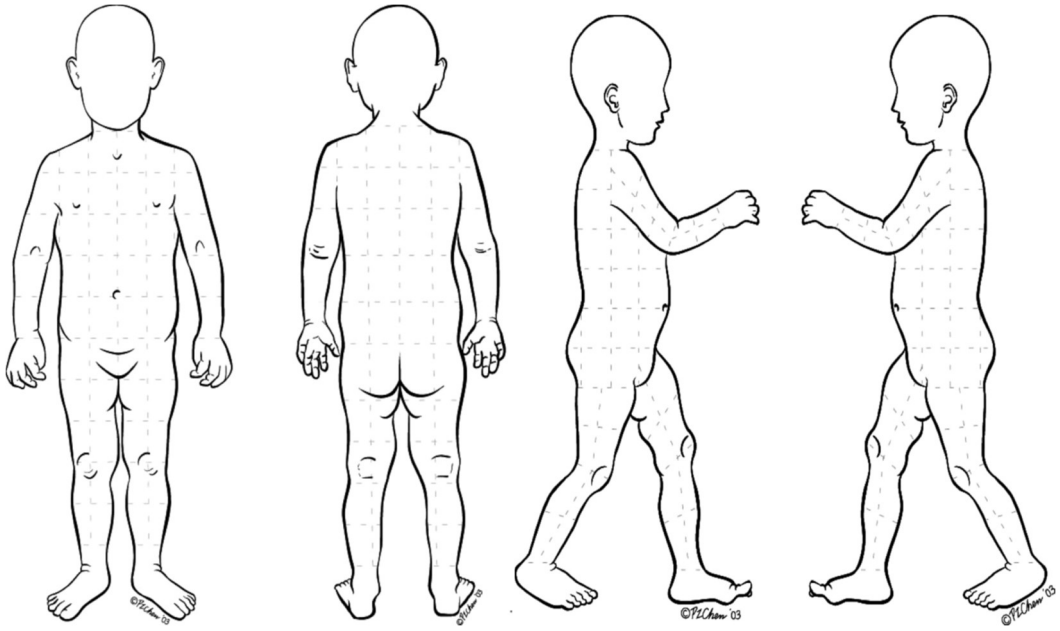
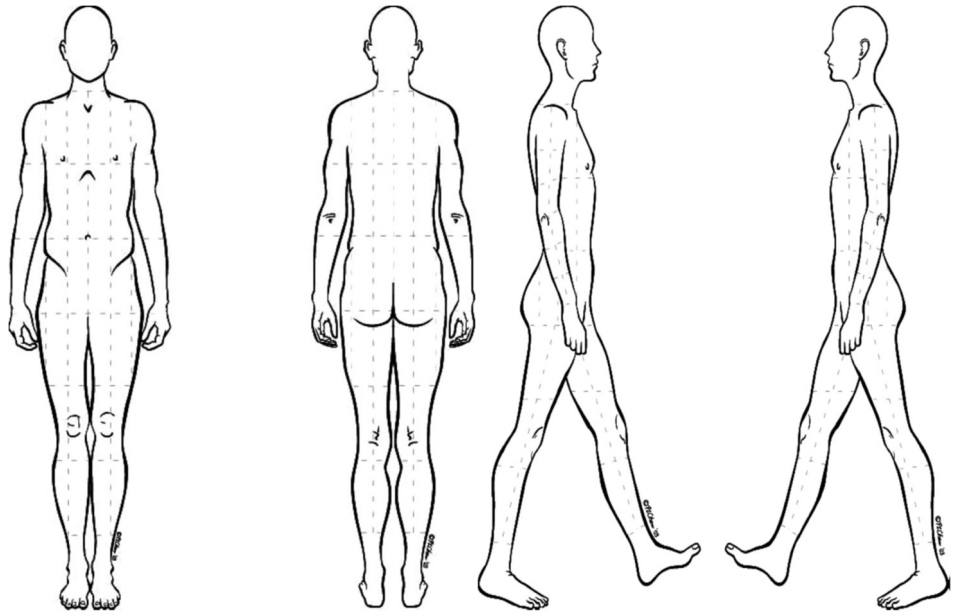


Fig -2: ADULT: Mark the injection site(s) of the vaccines given and location of any swelling/redness at or near injection site

Front Back Right side Left side



D) Past history of the child/adult:

S. no.	Question	Yes/no	If yes, specify
1.	Any illness following previous vaccinations that required medical attention/care		
2.	Any history of allergic reaction following previous vaccination		
3.	Any known history of allergy (to food items/drugs/materials etc)		
4.	Any known history of seizures/abnormal movements/breath holding spells/cyanosis		
5.	Any other known pre-existing illness		
6.	Any known history of hospitalization in last 30 days		

E) Nutritional status:
Weight (in kgs): _____ Date when taken (dd/mm/yyyy) ___/___/_____
(Check immunization card/medical records):

If weight not available, ask whether the child looked weaker/smaller as compared to babies of similar age: Yes /No

F) Personal history
1. H/o of systemic disorder:
Diabetes/Hypertension/Asthma/Epilepsy/Immunodeficiency/Tuberculosis/Any other medically diagnosed illness (Please specify_____)

2. H/o any addiction (if applicable): –Tobacco/Alcohol/i/v drugs use/ others (specify)
Frequency: _____
Since how long: _____

3. In case of woman: Was she pregnant: Yes/No/NA,
If Yes, LMP: DD/MM/YYYY PoG (in weeks): _____

Section 2.For Children (from 0- 5 years)
A) Birth details (check records if available):
Birth order:
Birth weight: …..grams
Child's size at birth if weight is unknown (Small/average/larger than average/unknown):
Place of delivery:
Type of delivery: Normal/caesarian/forceps
Was it a singleton/multiple delivery, specify……
Was s/he born premature (i.e. < 37 weeks): Yes/No
(If yes, please specify weeks_____)
Did s/he have any malformation/ birth defect at birth? Yes/No (If yes, please specify details_____)
Were there any complications during pregnancy/at birth? Yes/No (If yes, please specify details_____)
_____)
Did the child cry/breathe immediately after birth? Y/N /NK
Did the child require any breathing support at birth? Y/No/NK If yes, specify
Did the child require any hospitalization in first month of life: Y/N/NK, If yes, give details…….

B) Feeding history: For infants/children
When the child was first fed (breast feed/top feed) after birth: …minutes/hours
For how many months was the child given only breast feed: …… months
Was the child given any other feed than breast-feed: Yes/No
If yes, specify:

What was given and at what age	How (bottle/katori/spoon etc)	Frequency (per day)	Remarks

Who usually fed the child? _____

What foods and liquids was the child fed in **the last 24 hours before the death (include last feed)?**

Type of feed	Y/N	Frequency in last 24 hours	Time of the last feed (hours before death)
Breast milk			
Animal milk			
Water			
Other liquids			
Semi solids/ Solids			

Who last fed the child? _____

Section C: History of ~~previous~~ current illness
Did the child/adult have any of the following symptoms/signs?

Condition	**Unknown**	**No**	**Yes**	**Specify time & order of appearance and treatment given by family**
Fever				
Cold to touch				
Diarrhea/ Stool changes/ blood in stool				
Vomiting				
Fast/Difficulty in breathing				
Apnea (stopped breathing)				
Cyanosis (turned blue/grey)				
Swelling				
Lethargy or sleeping more than usual				
Fussiness or excessive crying				
Poor feeding/refusal to feed				
Altered sensorium				
Seizures or convulsion				
Weakness of limbs/ any part of the body				
Skin rash/flushing				
Choking				
Excessive sweating				
Any other, describe				

Injury/ Accident
Did s(he) suffer an injury or accident in last one month? Yes / No, if yes please specify:

S. No.	Complication	Yes	No	Remarks (specify)
1.	Road traffic crash/ injury			
2.	Fall			

3.	Drowning			
4.	Poisoning			
5.	Bite or sting by venomous animals			
6.	Fire/burns			
7.	Violence (suicide, homicide, abuse)			
8.	Other injury (Specify _____)			

Was anything (other than usual) food/ medicine given to child? Yes/No, If yes, specify, what was given and when it was given_____

Did s(he) had history of travel since last month of the event? Yes/no, if yes, specify_____

C) Development status:

Refer to the table below and decide if the child's development is:

Appropriate for age/delayed: If delayed, give details:

_____

_____

Age/ milestones	**Gross Motor**	**Speech/language**	**Fine motor**	**Social**
3 months	Moves both arms and legs freely and equally when awake by 2 months	Coos or vocalize or gurgling by 2 months	Keeps hand open and relaxed by 2 months	Social smile by 2 months
6 months	Roll over/turn over in either direction by 6 months	Utters "p", "b", "m" by 6 months	Hold rattle by using whole palm by 6 months	Raises arms to be picked by parents by 6 months
9 months	Sit alone by 9 months	Babbles "baba", "dada"," mama" by 9 months	Transfer object from hand to hand by 9 month.	Enjoys peek-a-boo by 9 months
1 year	Crawl by 12 months	Says one meaningful word of a familiar object by 12 months	Pincer grasp by 12 months.	Differentiates familiar faces from strangers by 12 months
1 and ½ yr	Walk alone by 15-18 months	Says at least five words by 18 months	Scribble by 18 months	Imitate actions like "byebye", "Namaste" by 15 months
2 year	Climb upstairs and downstairs by 24 months	Says two words together like "mama-milk", "car-go" by 24 months	Feeds self with hand or by spoon by 24 months	Parallel play by 24 months

D) In case of death at home:

Question	Last known alive	When put to bed last	When Found dead
Where the child was placed last? (crib, bed, floor, jholi etc.)			
In which position? (Sitting/on back/on side/on stomach/unknown)			
What was the child wearing?			
How was the face positioned? (Face down on surface/face up/face side)			
What was the temperature inside child's room? (Hot/cold/normal/other, please specify)			
Was anyone sleeping with/ near the child?			
Which of the following items were found/placed near the child? (like Toys/pillows/polythene bags/blankets/sheet/others, please specify _____)			
Was any electrical/traditional equipment used to heat the room/area where the event occurred?			

When the infant was found, was s/he? Breathing/ not breathing
If not breathing, did you witness the infant stop breathing? Yes/No
What hads led you to check on the infant?
Describe the infant's appearance when found: Please let the respondent narrate. Ask specifically for the following if not mentioned.

Appearance	**Unknown**	**No**	**Yes**	**Describe and specify location**
Discoloration around face/nose/mouth				
Secretions (foam, froth, blood)				
Skin discoloration				
Pressure marks (pale areas/blanching)				
Rash or petechiae (small, red blood spots on skin, membranes, or eyes)				

Marks on body (scratches or bruises)				
Other				

What did the infant feel like on touching when found?
(Sweaty/warm to touch/cool to touch, limp/ /rigid or stiff /unknown /others, please specify

_____

Did anyone try to revive the child? Yes/No (If yes, give details_____)

Section 3: Treatment and health services used (Especially for cases with insufficient medical records)

<table>
<tr><td rowspan="7">1</td><td colspan="4">Did the child/person receive any treatment for this event prior to death</td><td>YES /NO</td></tr>
<tr><td colspan="4">If yes, can you please list the treatments child/person was given in order?</td><td rowspan="6"></td></tr>
<tr><td>Provider/Facility (please write name)</td><td>What was given (tick all that apply)</td><td>Outcome (tick as applicable)</td><td>Any document available</td></tr>
<tr><td>1. First contact</td><td>☐ Oral
☐ Injectable
☐ IV fluid
☐ Local application</td><td>☐ Deteriorated
☐ No change
☐ Improved
☐ Referred</td><td>☐ Yes
☐ No</td></tr>
<tr><td>2. Second contact</td><td>☐ Oral
☐ Injectable
☐ IV fluid
☐ Local application</td><td>☐ Deteriorated
☐ No change
☐ Improved
☐ Referred</td><td>☐ Yes
☐ No</td></tr>
<tr><td>3. Third contact</td><td>☐ Oral
☐ Injectable
☐ IV fluid
☐ Local application</td><td>☐ Deteriorated
☐ No change
☐ Improved
☐ Referred</td><td>☐ Yes
☐ No</td></tr>
<tr><td>4. Add more if needed</td><td></td><td></td><td></td></tr>
<tr><td colspan="4">Please take a copy of the documents from the family/obtain hospital records for each contact. All medications should be verified by prescription where possible</td></tr>
<tr><td>2</td><td colspan="3">Did a health treating care provider tell you the cause of event?</td><td>Yes/no</td></tr>
<tr><td></td><td colspan="3">In the month before event, did you seek care for any other illness (medical/ surgical) of your child/ the person?</td><td>Yes/no</td></tr>
<tr><td></td><td colspan="3">If yes, what was the illness?</td><td></td></tr>
</table>

3	If yes, can you please list the treatments child/person was given in order for any illness prior to this one in the last one month?	

Provider/Facility (please write name)	What was given (tick all that apply)	Outcome (tick as applicable)	Any document available
1. First contact	☐ Oral ☐ Injectable ☐ IV fluid ☐ Local application	☐ Deteriorated ☐ No change ☐ Improved ☐ Referred	☐ Yes ☐ No
2.Second contact	☐ Oral ☐ Injectable ☐ IV fluid ☐ Local application	☐ Deteriorated ☐ No change ☐ Improved ☐ Referred	☐ Yes ☐ No
3.Third contact	☐ Oral ☐ Injectable ☐ IV fluid ☐ Local application	☐ Deteriorated ☐ No change ☐ Improved ☐ Referred	☐ Yes ☐ No
4. Add more if needed			

Please take a copy of the documents from the family/obtain hospital records for each contact. All medications should be verified by prescription where possible

Providers: Home/ Traditional healer /Government clinic/Government hospital/private clinic /private hospital/pharmacy, drug seller, store / any other place or facility_____

Section 4: Family History the following questions are to be filled based on asking or observation of the family during the interview

Ask Number of people staying in the house and relation to the child /person:
Observe Socio economic status:
Observe Health status of siblings:
Ask Consanguinity Yes/No (If yes, specify_____)
Ask recent illness in family Yes/No (If yes, specify_____)
Ask History of similar illness to any child in family/:
Observe Presence of adverse family circumstances (family relationships /economics/behavioural/addictions/circumstantial evidence): Yes/No (If yes, specify_____)
Any other significant factor:

Section 5: Any additional information/narration by the family members / respondent's other comments /observations about circumstances of the event…….

Section 6: Interviewer's impression * (Case Summary)
(Emphasis should be placed on establishing exact chronology of event from point of vaccination to occurrence of event)

Comments on specific questions/ any other comments:

Attach copies of all available documents (including case sheets, discharge summary, laboratory reports and post mortem reports)
*(To be filled in after completing interview)

Name of Interviewer:

Designation:
Address:

Contact no.:
Email:
Fax:
Signature and Date: