



Death			
Date medical team aware of death	___/___/_____ <i>D D / M M / Y Y Y Y</i>	Time child last seen alive by medical team	__:__
Time medical team aware of death	__:__	Primary Carer present at time of death?	<input type="checkbox"/> Y <input type="checkbox"/> N

Resuscitation		
Resuscitation attempted	Y	N
Duration of resuscitation	___ minutes <input type="checkbox"/> Unknown	N/A
Resuscitation details	<input type="checkbox"/> Bag and mask ventilation <input type="checkbox"/> Chest compressions <input type="checkbox"/> Adrenaline <input type="checkbox"/> Other _____	<input type="checkbox"/> Too late <input type="checkbox"/> Clinical team agree futility <input type="checkbox"/> Uncertain <input type="checkbox"/> Other _____

Answer the following question based on clinical notes, and clinician verbal report:

Section 1: CHILD INJURIES AND ACCIDENTS

Verbal Autopsy	
Did the child suffer an injury or accident that led to death? <i>Select 1</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused to answer
<i>If not in notes, and clinicians cannot answer, skip to section 2: Background. CHAIN participants should have been excluded if admitted with trauma, however some may be disclosed after death.</i>	
What kind of injury or accident did the child suffer from? <i>Select all that apply</i>	<input type="checkbox"/> Road traffic crash/ injury <input type="checkbox"/> Poisoning <input type="checkbox"/> Significant fall <input type="checkbox"/> Burn/Fire <input type="checkbox"/> Drowning <input type="checkbox"/> Homicide, abuse <input type="checkbox"/> Bite or sting by venomous animal <input type="checkbox"/> Refused to answer <input type="checkbox"/> Other injury, specify _____ <input type="checkbox"/> Don't know

Adapted from Population Health Metrics Research Consortium Shortened Verbal Autopsy Questionnaire Child Module



<b>Was the injury or accident intentionally inflicted by someone else?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused to answer
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**SECTION 2: BACKGROUND**

<b>How long did the illness last?</b>	<input type="checkbox"/> <24h                    ___ ___ days                    ___ ___ months <input type="checkbox"/> Don't know
<b>How old was the deceased at the time of death?</b>	___ ___ months

**SECTION 3: INFANT AND CHILD DEATHS**

<b>During the illness that led to death did the child have a fever?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>How many days did the fever last?</b>	<input type="checkbox"/> Less than 24 hours                    ___ ___ days <input type="checkbox"/> Don't know
<b>Did the fever continue until death?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>How severe was the fever?</b>	<input type="checkbox"/> Mild <38C <input type="checkbox"/> Moderate 38-39.5C <input type="checkbox"/> Severe >39.5C <input type="checkbox"/> Don't know
<b>During the illness that led to death, did the child have more frequent loose or liquid stools than usual?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>How many stools did the child have on the day that loose or liquid stools were most frequent?</b>	___ ___ stools <input type="checkbox"/> Don't know
<b>Did the frequent loose or liquid stools continue until death?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>During the illness that led to death, did the child have a cough?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>For how many days did the cough last?</b>	___ ___ days <input type="checkbox"/> Don't know
<b>Was the cough very severe?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>During the illness that led to death, did the child have difficulty breathing?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>For how many days did the difficult breathing last?</b>	___ ___ days <input type="checkbox"/> Don't know
<b>During the illness that led to death, did the child have fast breathing?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>For how many days did the fast breathing last?</b>	___ ___ days <input type="checkbox"/> Don't know
<b>During the illness that led to death, did he/she have indrawing of the chest?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>During the illness that led to death, did his/her breathing sound like grunting?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>Did the child experience any generalized convulsions or fits during the illness that led to death?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>Was the child unconscious during the illness that led to death?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

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How long before death did unconsciousness start?	<input type="checkbox"/> Less than 6 hours	<input type="checkbox"/> 6-23 hours	
	<input type="checkbox"/> 24 hours or more	<input type="checkbox"/> Don't know	
Did the child have a stiff neck during the illness that led to death?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Did the child have a bulging fontanelle during the illness that led to death?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
During the month before he/she died, did have a skin rash?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
How many days did the rash last?	___ ___ days		<input type="checkbox"/> Don't know
During the illness that led to death, did the child's skin flake off in patches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Did the child's hair change in color to a reddish or yellowish color?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Did the child have a protruding belly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
During the illness that led to death, did the child suffer from anaemia or pallor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
During the illness that led to death, did the child have swelling in the armpits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
During the illness that led to death, did the child bleed from anywhere?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
During the illness that led to death, did he/she have areas of the skin that turned black?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know

SECTION 4: HEALTH RECORDS

Is the cause of death known/recorded?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
What was the cause of death?	_____		
Record the name and address of the hospital, health center or clinic where the care was sought:	_____		
What was the date of death	___ / ___ / _____		<input type="checkbox"/> Don't know
	<i>D D / M M / Y Y Y Y</i>		
Was a death certificate issued?	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Is the death certificate available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Don't know
Record the immediate cause of death from the certificate.	_____		
	<input type="checkbox"/> N/A		
Record the other underlying causes of death from the certificate.	_____		
	<input type="checkbox"/> N/A		

END