CONFIDENTIAL

Ministry of Health

Field Case Review Format for Under - 5 Child Deaths

FS3

MOH Area :	RDHS Area:	Pregnancy / Birth & Immunization Registration No:

A	Basic Information				
1	Name of Infant / Child		9	Date of Birth	DD /MM / YYYY
2	Sex	*Male / Female / Ambiguous*	10	Birth Certificate No:	
3	Ethnicity	*Sinhalese / Tamil / Muslim / Other*	11	Date of Death	DD /MM / YYYY
4	Name of Mother		12	Age at death	_____ *Days* _____ *Hours*
5	Residential Address		13	Place of death	*Home / Field / On admission / Hospital*
6	PHM Area		14	Name of Hospital	
7	GS Division		15	BHT No: *(if hospital)*	
8	Eligible Family Registration No:		16	Unit of Hospital	*Ward No: / SCBU / ICU*

B	**Short History** *(from the onset of the illness up to death)**
	**Please indicate chronology of events with details about onset of illness, Symptoms, consultations, investigations done, treatment / management done both at outpatient & inward levels*

C	Post mortem / Necropsy Findings		
	Pathological / Forensic Record No:_____	*Done* ☐ *Not done* ☐	*Please give details:*

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

E	Death Registration Information	***Please attach a copy of the Death Certificate.*** ***Death Certificate No:*** *If not registered, please give reasons*

F	Socio-Demographic details				
1	Marital status of parents	Unmarried / Married / Living together / Widowed / Divorced	7	Father's educational level	*None / Primary Gr 1-5 / Secondary Gr 6 – 11 / Secondary Gr 12 - 13 / Tertiary*
2	Age of Mother	_____ *Years*	8	Father's occupation	
3	Mother's Religion		9	Father's Religion	
4	Mother's educational level	*None / Primary Gr 1-5 / Secondary Gr 6 – 11 / Secondary Gr 12 - 13 / Tertiary*	10	Father's substance abuse	
5	Mother's occupation		11	Average Monthly Family Income	*Rs.*
6	Parity / No of living children in the family		12	Is this child is out of a planned pregnancy ?	*If '**No**' give details*

13	Any children with disabilities or congenital abnormalities ? Please give details.
14	Details of previous infant / child deaths in the family:
15	Comments on the living conditions: Poor / Average / Middle class / High class
16	Is there a good family relationship and bond among parents?*If '**No**' give details*
17	Give details of religious beliefs / taboos / practices etc which may affect health of children.
18	Social risk factors. Please list relevant 'Z' codes.
G	**Details related to the onset of illness & care received prior to death**
1	Was there any delay in seeking medical care by the parents / guardian ? **Yes** ☐ **No** ☐ If yes, please give the details & contributory factors;
2	Had the index infant / child have first contact level (Hospital OPD / General practitioners / Other medical practitioners) or home treatment prior to death ? **Yes** ☐ **No** ☐ *(If 'Yes', please give details. For hospital management please go to **H**)*
	If the infant / child <u>died outside hospital / health facility</u>, please give a detailed description: Was an inquest held ? *If '**Yes**', please give details:*
3	Any identified delays/deficiencies in receiving healthcare for this infant / child prior to death;

H	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	Give details of transport mechanism used to take the infant to the hospital:											
4	Date of admission to hospital: DD / MM / YYYY Time: ___:____ *am/pm* Ward:_____ BHT No: _____											
5	**Presenting complaints and condition at the time of admission:**											
6	**Past Medical Conditions & details:**								**7. Family History:** **8. Consanguinity : Yes ☐ No ☐**			
9	**Details of previous hospital admissions:**											
10	Summary of clinical findings / investigations / diagnoses& management at hospital: ***Please attach copies of clinical records / diagnosis cards available with parents.***											
11	Categories of senior clinicians saw/attended to the sick infant / child :	Senior House Officer (SHO) / DMO ☐ Registrar / Senior Registrar ☐ Paediatrician ☐ Other☐ (Please specify)……										
12	Parent's view on the care received by the deceased infant: Poor / unsatisfactory / Satisfactory / Excellent (Give details)											

I	**Ante-natal care** *(For all neonatal deaths and post-neonatal deaths if indicated)*			
1	Comments on the pre-pregnancy period (maternal diseases / risk factors) in relation to the condition the infant suffered:			
2	Details of registration of pregnancy, booking visit and provision of antenatal care:			
3	Was mother immunized against rubella ?	Yes / No	**4.** BMI & the weight gain during pregnancy	
5	Were there any maternal diseases OR other risk conditions identified during pregnancy contributing to the illness of the diseased infant ?*(Please give details)*			
6	Was the mother properly educated on danger signs during and after pregnancy, foetal wellbeing and newborn care ? *(Please give details)*			
7	Are you satisfied with the overall antenatal care the mother received ? *Please give details on deficiencies noted.*			

J	**Birth History** *(For all neonatal deaths and post-neonatal deaths if indicated)*		
1	Gravida		**2.** Parity: |**T P A L**
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	Date of birth registered	DD / MM / YYYY| *If not registered, please give reasons:*	
9	Birth Weight	_____ *grams*	**10.** Birth attended by: Midwife / Nurse / HO / SHO / Registrar / VOG
11	Apgar score at delivery	5 minutes 10 minutes	**12.** Maturity at Birth: _____ wks
13	Complications at birth / during neonatal period : **Yes** ☐ **No** ☐ *(If 'Yes' , please give details)*		
14	Whether resuscitation needed at birth ? If yes, resuscitated by a trained person?Modes of resuscitation ?		
15	Were there any reasons for special care (SCBU /ICU)? **Yes** ☐ **No** ☐ *(If 'Yes' , please give details)*		
16	Details of the condition of the newborn on discharge:		
17	Any congenital abnormalities / Child with Special Healthcare Needs ? **Yes** ☐ **No** ☐ *(If 'Yes' , please give details)*		
18	Details on whether breastfeeding was established&initiation of exclusive breastfeeding:		

K	Provision of Field Care		
1	Date of infant registered in the Birth & Immunization Register	DD / MM / YYYY *(If not registered, please give reasons)*	
2	Status of the PHM area	*Active / Vacant / On leave (If not 'Active' , please give details)*	
3	Was there any reason for special care ? Please give details.		
4	Details of encounters / findings by the MOH at Child Well Baby Clinics:		
5	Details of EPI vaccines given. If the infant / child has not received age appropriate immunization, please give reasons:		
6	Was the baby exclusively breastfed ? If not why ?		
7	Details of introducing complementary feeding:		
8	Comment on growth monitoring (Please also state number of times the infant / child was weighed& actions taken)		
9	Give your opinion on the care given by the family members to the infant / child and the home environment including safety:		
10	Details of PHM home visits done for infant / child care:		
11	How do you rate the care given by the area PHM to this infant / child ?	*Excellent / Very Good / Good / Average / Poor*	

L	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/ facilities and other logistics:

7	Deficiencies in healthcare administration (National / Provincial / Regional / Divisional) contributing to the death:
8	Any issues / problems of outside health sector contributing to this death:
9	**Preventability** (Filling of this field is mandatory. Give your opinion on preventability) Preventable ☐ Unpreventable ☐ Inconclusive ☐ *Remarks:*

J	**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 your field team were providing care to this infant and/or mother 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?

K	**Lessons learnt & actions taken**			
1. Date of this death discussed at monthly conference	DD / MM / YYYY	**2.**Who presented the case ?		
3. *Describe the lessons learnt out of the index death & actions already taken or proposed to rectify the issues / deficiencies.*				
4. Date field death notification sent	DD / MM / YYYY	**5.**Date of field death review conducted	DD / MM / YYYY	

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

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

Contact Phone *(Mobile No)*: Official Stamp:

Please prepare this report in triplicate and send one copy each to: ***Director / Family Health Bureau*** *and* ***Regional Director of Health Services****. Keep the remaining copy for official purposes at your institution.*

Data in this format should be entered to **National Field Under – 5 Child Death Register**: *https://erhmis.fhb.health.gov.lk/mmsbds/dhis-web-*