DATA DEFINITION *STILLBIRTH AND UNDER 5 MORTALITY*

(SU5MR-I/2012)

Important Notes:

- Please complete the form for all of **birth ≥ 500gm** or 22 completed weeks of pregnancy if birth weight is unknown.
- Stillbirth– Please complete **ALL SECTIONS EXCEPT SECTION 3 AND 4**
- Neonatal Deaths – Please complete **ALL SECTIONS**
- 28 Days - < 5 Years –Please complete **ALL SECTIONS EXCEPT SECTION 5 AND 6A**

No	Data	Definition
A.	**Reporting Centre/District**	Hospital/Centre/District where death occurs
	MRN	Hospital registration number
	Place of death	Please TICK (√) relevant box
	Type of death	Please TICK (√) relevant box * Please specify birth weight for stillbirth and neonatal death
B.	**Date of form filled/ Date of interview**	Date of form filled OR interview
SECTION 1 : PATIENT DETAILS		
1.	**Name**	Name of the child as in Mykid
2.	**MyKid No/ Other ID No**	MyKid Number OR Mother's MyKad number OR other ID number OR No document
3.	**Residence**	Fill in the resident address of the child
	a. Postcode	
	b. City/Town	
	c. District	
	d. State	
4.	**Current address**	Please write down the current address
5.	**Ethnicity (citizen only)**	Please TICK (√) relevant box
6.	**Gender**	Please TICK (√) relevant box
7.	**Immunisation status: up to age**	Please TICK (√) relevant box Please specify if immunisation not complete
SECTION 2 : PARENTS DETAILS (Fill in details of **Mother AND Father** if both parents are guardians;		

No	Data	Definition	
Fill in details of either mother OR father if single parent)			
8.	**Parents**	Mother	Father
	a. Age	Age of the mother	Age of the father
	b. Citizen	Please TICK (√) relevant box Non citizen **legal** – Non citizen with valid passport/ other ID document Non citizen **illegal** – Non citizen with invalid OR expired passport Please specify country of origin if non citizen	Please TICK (√) relevant box Non citizen **legal** – Non citizen with valid passport/ other ID document Non citizen **illegal** – Non citizen with invalid OR expired passport Please specify country of origin if non citizen
	c. Education level	Please TICK (√) relevant box	Please TICK (√) relevant box
	d. Occupation	Please TICK (√) relevant box Please specify in column others eg student	Please TICK (√) relevant box Please specify in column others eg student
	e. Marital status	Please TICK (√) relevant box	Please TICK (√) relevant box
	f. Combined household income	Please TICK (√) relevant box	Please TICK (√) relevant box
SECTION 3 : PATIENT 'S DEATH DETAILS – Please fill in Section 3a & 3b based on place of death			
9.	**a. Date of Birth: (dd/mm/yyyy)** **b. Age at death**	Date of birth in the form of dd/mm/yyyy e.g. 01/01/2013 if it is 1 January 2013 Age of the child at death in the form of year/month/day/hour/min	
10.	**Date and time of Death**		
	a. Date (dd/mm/yyyy)	Date of death in the form of dd/mm/yyyy e.g. 01/01/2013 if it is 1 Januari 2013	
	b. Time	Time according to 12 hour system (am/pm) e.g 11 00 pm if death at 11 o'clock in the evening 12 45 pm if death at 12.45 o'clock in the afternoon 01 00 am if death at 1 o'clock in the morning	

No	Data	Definition
11.	**Death Certificate issued by**	Please TICK (√) relevant box **AND SPECIFY THE OFFICER who certify the death**
12.	**Cause of Death (as in death certificate)**	Please write the cause of death as in death certificate
SECTION 3a : HOSPITAL DEATH ONLY (0 - < 5 years)		
13	**Place of Death**	Please TICK (√) relevant box
14	**Hospital Treatment**	**Please TICK (√) relevant box in column a. AND b.**
	a. Highest level Care Received:	Please TICK (√) relevant box
	b. Highest level of person managing	Please TICK (√) relevant box
SECTION 3b : NON-HOSPITAL DEATH ONLY (0 - < 5 years)		
15	**Place of Death**	Please TICK (√) relevant box
SECTION 4 : Please TICK (√) Not Applicable if no symptoms leading to death AND no treatment received		
16.	**Symptom(s) of current illness leading to death:**	Please TICK (√) relevant box if there is/are symptom(s) of current illness leading to death. If there is no symptoms, please TICK (√) *Not Applicable* **PLEASE ATTACH ADDITIONAL INFORMATION IF ANY**
Please complete number 17 ONLY IF you (√) one or more boxes in 16. (Except Not Applicable)		
17	**Treatment(s) received for current illness?**	Please TICK (√) relevant box and specify number of visits to the chosen place of treatment. **PLEASE ATTACH ADDITIONAL INFORMATION IF ANY**
18.	**Co-Morbid Condition**	Please TICK (√) relevant box. If YES, please TICK (√) what is/are the conditions
SECTION 5: FOR STILLBIRTH AND NEONATAL DEATH ONLY		
MOTHER PREGNANCY DETAILS		
19	**Gravida/Para/Abortion**	Please fill in mothers gravid/para/abortion details
20	**Gestational age at delivery**	Please fill in gestational age weeks/days (eg. 33 weeks/5 days)
21	**Gestational age based on:**	Please TICK (√) relevant box

No	Data	Definition
22	**Date and time of delivery:**	**Date** (dd/mm/yyyy) Time : hh:mm am/pm (eg 11:30 pm)
23	**Place antenatal care received**	Please TICK (√) relevant box: *Please indicate the District and State with most number of antenatal visits*
24	**Place of delivery:**	Please TICK (√) relevant box
25	**Delivery details:**	Please TICK (√) relevant box
26	**No. of fetuses/babies in this pregnancy**	Please TICK (√) relevant box For multiple pregnancies, please specify birth order
27	**Current obstetric/ medical problems:**	Please TICK (√) relevant box
28	**Timing of death (stillbirth only)**	Please TICK (√) relevant box
29	**Classification of Death (Modified Wigglesworth)**	Please TICK (√) relevant box
30	**Death Classification**	Please TICK (√) relevant box
SECTION 6: TO BE FILLED UP BY MEDICAL OFFICER IN CHARGE/SPECIALIST AT PLACE OF DEATH		
SECTION 6A : SHORTFALLS IN CASE MANAGEMENT (FOR STILLBIRTH AND NEONATAL DEATH ONLY)		
1 **1.1 – 1.8**	**ANTENATAL CARE**	Please TICK (√) relevant box: Yes ☐ No ☐ Not Applicable ☐ Please write information at specify column if any
	Comments by O&G Head of Department/ Officer in charge **Prepared by**	Please write comments if any Name, designation and date
2 **2.1 – 2.6**	**INTRAPARTUM CARE**	Please TICK (√) relevant box: Yes ☐ No ☐ Not Applicable ☐ Please write information at specify column if any
	Comments by Head of Department/ Officer in charge **Prepared by**	Please write comments if any Name, designation and date
3 **3.1 –**	**NEONATAL (For neonatal death only)**	Please TICK (√) relevant box: Yes ☐ No ☐ Not ☐

No	Data	Definition
3.8	Please TICK (√) one: ☐ Public hospital ☐ Private facilities	Applicable Please write information at specify column if any
	Comments by Head of Department/ Officer in charge **Prepared by**	Please write comments if any Name, signature and date
3.9	**Reported by**	Name, designation, signature and date
3.10	**Verified by**	Name, designation, signature and date
SECTION 6B : REMEDIABLE FACTORS (FOR ALL DEATHS) To be filled up by District/Hospital Committee		
4 **4.1–4.11**	**Remediable clinical factors** Please TICK (√) one: ☐ Present ☐ Absent	If present, please choose the relevant subgroup of Substandard Care if present • For **Stillbirth**, fill in the column **ANTEPARTUM** only • For **Neonatal death**, fill in **ALL** columns (ANTEPARTUM, INTRAPARTUM and POST PARTUM - < 28 days) • For **28 days - < 5 years**, fill in the column **28 DAYS - < 5 YEARS ONLY** Please attach any information if ANY
5 **5.1-5.12**	**Remediable non-clinical factors** Please TICK (√) one: ☐ Present ☐ Absent	If present: **5.1 -5.2**: Fill in the column **Postpartum - < 28 days/ 28 days - < 5 years only** **5.4**: Fill in the column **ANTEPARTUM and INTRAPARTUM only** **5.8 - 5.9**: Fill in the column **INTRAPARTUM (Private Clinic/Hospital – PR only) and Postpartum - < 28 days** **5.3, 5.5 – 5.7, 5.10, 5.11, 5.12: all COLUMNS** Please attach any information if ANY
6 **6.1-6.7**	**Patient/ family factors** Please TICK (√) one: ☐ Present ☐ Absent	If present: **6.1: For stillbirths and neonatal deaths only** **6.2 – 6.7: For ALL DEATHS** Please attach any information if ANY
SECTION 7: DECISION BY HOSPITAL/DISTRICT UNDER 5 MORTALITY TECHNICAL COMMITTEE MEETING		
7.1	**Cause of Death**	To be filled in after CONCENSUS during under 5 mortality technical meeting at hospital and district level

No	Data	Definition
	a. IMMEDIATE CAUSE (final disease or condition resulting in death)	Please write immediate cause of death
	b. Sequentially list conditions if any leading to the cause listed in a. Enter the UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death)	Please write *Sequentially list conditions* and *Underlying Cause* of death
7.2	**Suspected Child Abuse and Neglect (SCAN)**	Please TICK (√) Yes, No Or Not Sure
7.3	**Post mortem**	Please TICK (√) Yes, No or Not applicable
7.4	**ICD Classification of Cause of Death** **Specify Details**	Please TICK (√) one according to ICD 10 classification Please specify details
7.5	**Substandard Care**	Please TICK (√) Yes Or No
7.6	**Preventable Death**	Please TICK (√) Yes, No OR Undetermined
7.7	**Remedial action by hospital/ district**	Please specify
	Report prepared by	Name, designation and date
	Verified by	Name, designation and date
7.8	**Consolidation Report** To be completed by District Medical Officer of Health-Please use additional sheets	
i	**Particular of patient and family**	Age/Race/Sex/Sibling of…/Date of death/Place of death
ii	**History of current illness**	Chronology of symptom/duration/treatment received and management at hospital/health clinic/private facilities/self-treatment before death History of breastfeeding and immunisation up to age and also Growth Development should be included if relevant
iii	**Co-morbid condition**	Please specify and explain the condition that can contribute to death Please explain the management of co-morbid condition at hospital/health clinic/private facilities if any. e.g management of congenital heart disease,malignancy etc.
iv	**Cause of death/Classification of death**	Classification of Death according to ICD 10

No	Data	Definition
v	**Preventable Death OR Not Preventable Death**	Summary of whether preventable or not preventable and reasons
vi	**Substandard Care**	Summarize the Substandard Care at different level of care/ management at hospital/health clinic/private facilities that contribute to the death - Remediable Clinical Factors - Remediable Non-Clinical Factors - Patient/Family Factors
vii	**Remedial Action**	Remedial actions that have been taken/undertaken and status of implementation at DISTRICT AND STATE LEVEL
	Conclusion: (by District Medical Officer of Health)	Please specify
	Validated by District Medical Officer of Health	Name, signature, designation and date
Section 8: Decision by STATE Under 5 Mortality Technical Committee Meeting		
8.1	**Cause of Death**	To be filled in after CONCENSUS during under 5 mortality technical meeting at state level
	a. IMMEDIATE CAUSE (final disease or condition resulting in death)	Please write immediate cause of death
	b. Sequentially list conditions if any leading to the cause listed in a. Enter the UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death)	Please write *Sequentially list conditions* and *Underlying Cause* of death
8.2	**Suspected Child Abuse and Neglect (SCAN)**	Please TICK (√) Yes, No Or Not Sure
8.3	**Post mortem**	Please TICK (√) Yes, No or Not applicable
8.4	**ICD Classification of Cause of Death** **Specify Details**	Please TICK (√) one according to ICD 10 classification Please specify details
8.5	**Substandard Care**	Please TICK (√) Yes Or No
8.6	**Preventable Death**	Please TICK (√) Yes, No OR Undetermined

No	Data	Definition
8.7	**Remedial action by state**	Please specify
	Conclusion: (by State Director of Health)	Please specify
	Validated by State Director of Health	Name, signature, designation and date