Thank you for your interest in the work of the Vaccine Trials Inquiry, the remit of which will already have been explained to you. Further and more detailed information is now required by the Inquiry in order to further progress the investigation.

We now ask you to complete this questionnaire by providing as many details as possible. The Inquiry team fully understands that due to age at the time of the vaccine or due to other circumstances, individuals will have difficulty in answering all the questions. However, please do your best in this regard and return the completed questionnaire by Friday, 17th May 2002 to:

The Vaccine Trials Inquiry,  
Commission to Inquire into Child Abuse,  
Floor 2,  
St. Stephen’s Green House,  
Earlsfort Terrace,  
Dublin 2.

Please note that the Commission cannot proceed with your inquiry unless a completed questionnaire is returned.

If you have any difficulty completing the questionnaire or any other problem in relation to it you can telephone us at:

(01) 662 4444 / Callsave 1850 20 11 20 (Republic of Ireland)  
LoCall 0845 309 8139 (N.I. & U.K.)

Office hours are from 9:30 a.m. to 1:00 p.m. and from 2:00 p.m. to 5:30 p.m.
**PART I** | **YOUR OWN DETAILS:**
---|---
1.1 **Current Surname:** *(What Surname are you now known by?)*
1.2 **First Name(s):** *(What First name(s) do you use today?)*
1.3 **Title** *(Mr., Ms., Miss, Mrs, Prof., Dr, etc.,)*
1.4 **Contact address:** *(Address for correspondence)*
1.5 **Contact telephone number(s):** *(Phone numbers for contact. Home incl. codes, mobile etc.)*
1.6 **First Name(s) when a child:** *(If different to present name):*
1.7 **Surname(s) when a child:** *(Maiden name, and/or pre-adoption name etc., if applicable.)*
1.8 **Date of Birth:** *(Please be as accurate as possible e.g. 12/12/1912)*
1.9 **Place of Birth** *(Please be as precise as possible e.g. number, street, townland, city)*

---

Reference number: **VTI**
*For Office Use Only*
**PART II**

**INSTITUTIONS**

2.1 If you spent time as a resident in an institution, please furnish the name of the institution and the date(s), month(s) and year(s), if known, when you were resident there:

<table>
<thead>
<tr>
<th>Institution/ Place</th>
<th>Date(s) you were there</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Please give name and location)</td>
<td>(Please be as exact as possible)</td>
</tr>
<tr>
<td>1. ____________________________________</td>
<td>From: __________ To: __________</td>
</tr>
<tr>
<td>2. ____________________________________</td>
<td>From: __________ To: __________</td>
</tr>
<tr>
<td>3. ____________________________________</td>
<td>From: __________ To: __________</td>
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<tr>
<td>4. ____________________________________</td>
<td>From: __________ To: __________</td>
</tr>
<tr>
<td>5. ____________________________________</td>
<td>From: __________ To: __________</td>
</tr>
<tr>
<td>6. ____________________________________</td>
<td>From: __________ To: __________</td>
</tr>
<tr>
<td>7. ____________________________________</td>
<td>From: __________ To: __________</td>
</tr>
</tbody>
</table>

2.2 Do you remember the name(s) of any of the people in charge of, or working in the institution at the time?

If yes, please give details;

(a) Institution ____________________________________________________________

(b) Name of person(s): ____________________________________________________

(c) Position(s) in the Institution ____________________________________________
    (e.g. manager, teacher, nurse)

(a) Institution ____________________________________________________________

(b) Name of person(s): ____________________________________________________

(c) Position(s) in the Institution ____________________________________________
    (e.g. manager, teacher, nurse)
(a) Institution _____________________________________________________________

(b) Name of person(s): ____________________________________________________

(c) Position(s) in the Institution ____________________________________________
    (e.g. manager, teacher, nurse)

(a) Institution _____________________________________________________________

(b) Name of person(s): ____________________________________________________

(c) Position(s) in the Institution ____________________________________________
    (e.g. manager, teacher, nurse)

(a) Institution _____________________________________________________________

(b) Name of person(s): ____________________________________________________

(c) Position(s) in the Institution ____________________________________________
    (e.g. manager, teacher, nurse)

(a) Institution _____________________________________________________________

(b) Name of person(s): ____________________________________________________

(c) Position(s) in the Institution ____________________________________________
    (e.g. manager, teacher, nurse)

(a) Institution _____________________________________________________________

(b) Name of person(s): ____________________________________________________

(c) Position(s) in the Institution ____________________________________________
    (e.g. manager, teacher, nurse)
PART III

VACCINE TRIALS

Note: A Vaccine Trial is an organised programme conducted to test the strength (potency) of a vaccine, the effectiveness of the vaccine, the method by which it is given or the effect on the person vaccinated. A vaccine trial is different to a standard vaccination that is often given in childhood as part of a generally available immunisation programme. A list of childhood immunisation (vaccination) programmes is included at the end of the questionnaire.

3.1 Do you think that you **were** involved in a vaccine trial or trials?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Please tick relevant box)

3.2 If yes, upon what basis do you think that you were involved in a vaccine trial?

(May be personal recollections, medical records, information received or physical evidence including marks)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3.3 Do you suspect that you **may** have been involved in a vaccine trial or trials?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Please tick relevant box)

3.4 If yes, upon what basis do you suspect that you may have been involved in a vaccine trial?

(May be personal recollections, medical records, information received or physical evidence including marks)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
3.5 Where do you think the vaccine trial(s) took place?
Name and address of institution(s), own home, clinic or other location(s)

1. _______________________________________________________________________________
2. _______________________________________________________________________________
3. _______________________________________________________________________________
4. _______________________________________________________________________________
5. _______________________________________________________________________________
6. ________________________________________________________________________________

3.6 When did the vaccine trial(s) take place?
(Please give as precise a date(s) as possible)
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

3.7 If you can, please describe the method by which the vaccine was administered?
(Injections, substance placed in nose, sugar lump by mouth etc.)
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

3.8 Where on your body was the vaccine administered?
(Please give details of location of vaccine(s))
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

3.9 What were the effects of the vaccine upon you?
(Are you aware of any effects, good or bad, resulting from the vaccine trial?)
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
3.10 Were you informed of what was happening?
(Was the vaccine process and reason explained to you?
   e.g. how it was going to happen and why)

YES  NO
(Please tick relevant box)

3.11 Did you understand what was happening?
(Did you understand the nature and purpose of the vaccine?)

YES  NO
(Please tick relevant box)

3.12 Were the persons involved introduced to you?
(Did you know the persons involved in the conduct of the vaccination trials?)

YES  NO
(Please tick relevant box)

3.13 Do you recall the name of the doctors, nurses or other professionals involved?
(Please furnish any details)

YES  NO
(Please tick relevant box)
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

3.14 Were you with a parent or other guardian at the time of vaccination?
(e.g. if you were living at home or in a mother and baby home etc.)

YES  NO
(Please tick relevant box)

If yes, please give details
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

+  +
3.15 If yes, was the vaccine explained to your parent or guardian?  
(Did your parent/guardian receive details of the vaccine you were given?)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

(Please tick relevant box)

3.16 To your knowledge did your parent or guardian consent to the vaccine?  
(Was parental consent given?)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

(Please tick relevant box)

3.17 Do you know how you were selected for the trial?  
(Can you recall why you were part of the trial?)

Please give details

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

3.18 Please give an account of your recollections:

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

3.19 Please provide details of anybody else you know who received the vaccine(s) at the same time?  
(Friends, fellow residents, brothers, sisters, etc.)

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
3.20 Are you still in contact with any of the persons listed at 3.19, above?

[ ] YES  [ ] NO

(Please tick relevant box)

3.21 If yes, please furnish any contact details known to you:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

3.22 Did you experience any adverse reaction(s) to the vaccine(s)?

[ ] YES  [ ] NO

(Please tick relevant box)

(If yes, please give details)

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

3.23 Did you experience any beneficial reaction?

[ ] YES  [ ] NO

(Please tick relevant box)

(If yes, please give details)

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________
3.24 Do you have any written or other record(s) of vaccinations?
(Are you in possession of any personal record concerning vaccine trials or vaccines generally?)

YES ☐  NO ☐

(Please tick relevant box)

(If yes, please give details)
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
+ +

3.25 Do you have on your body any marks related to vaccine trials?
(Have you vaccination marks that you believe may relate to a vaccine trial?)

YES ☐  NO ☐

(Please tick relevant box)

(If yes, please give details)
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
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_______________________________________________________________________________

+ +
4.1 Is there any living person(s) who might throw further light on your experiences? (e.g. a parent/guardian/sibling/adult at the time you were vaccinated and who is still alive today)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Please tick relevant box)

4.2 If yes, please give the name and contact details of such person(s):
(Name, address and phone number(s))

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

4.3 How do you think that person might be able to assist?
(Role or location of that person at time of vaccination)

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

+                               +

4.4 Please provide any other information that you think relevant:

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
4.5 If you have completed this questionnaire on behalf of another person, please indicate the relationship between you and that person.

Signature: ___________________

Date: ___________________

<table>
<thead>
<tr>
<th>National Childhood Immunisation (Vaccination) Programmes</th>
<th>Date of Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diptheria/Tetanus (DT)</td>
<td>1930s</td>
</tr>
<tr>
<td>BCG (to protect against tuberculosis)</td>
<td>1949</td>
</tr>
<tr>
<td>Diptheria/Tetanus/Pertussis (DTP)</td>
<td>1952/3</td>
</tr>
<tr>
<td>Polio</td>
<td>1957</td>
</tr>
<tr>
<td>Rubella</td>
<td>1971</td>
</tr>
<tr>
<td>Measles</td>
<td>1985</td>
</tr>
</tbody>
</table>