

Commission to Inquire into Child Abuse

Vaccine Trials Inquiry

Questionnaire

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.

PLEASE USE BLOCK CAPITAL LETTERS.
 ONE LETTER/ FIGURE PER BOX PLEASE
 LEAVE A SPACE BETWEEN WORDS.

Reference number:
VTI
**For Office Use Only*

PART I

YOUR OWN DETAILS:

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1.1 Current Surname: *(What Surname are you now known by?)*

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1.2 First Name(s): *(What First name(s) do you use today?)*

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1.3 Title *(Mr., Ms., Miss, Mrs, Prof., Dr, etc.,)*

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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):*

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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)*

DAY	DAY	/	MONTH	MONTH	/	YEAR	YEAR	YEAR	YEAR

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1.9. Place of Birth *(Please be as precise as possible e.g. number, street, townland, city)*

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:

Institution/ Place <i>(Please give name and location)</i>	Date(s) you were there <i>(Please be as exact as possible)</i>
1. _____	From: _____ To: _____
2. _____	From: _____ To: _____
3. _____	From: _____ To: _____
4. _____	From: _____ To: _____
5. _____	From: _____ To: _____
6. _____	From: _____ To: _____
7. _____	From: _____ To: _____

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

<input type="checkbox"/> YES	<input type="checkbox"/>	<input type="checkbox"/> NO	<input type="checkbox"/>
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(Please tick relevant box)

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)

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- (a) **Institution** _____
- (b) **Name of person(s):** _____
- (c) **Position(s) in the Institution** _____
(*e.g. manager, teacher, nurse*)

- (a) **Institution** _____
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(*e.g. manager, teacher, nurse*)

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(*e.g. manager, teacher, nurse*)

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- (b) **Name of person(s):** _____
- (c) **Position(s) in the Institution** _____
(*e.g. manager, teacher, nurse*)

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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?)

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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	
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(Please tick relevant box)

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

YES		NO	
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(Please tick relevant box)

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

YES		NO	
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(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	
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(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	
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(Please tick relevant box)

If yes, please give details

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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?)

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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(Please tick relevant box)

3.16 To your knowledge did your parent or guardian consent to the vaccine?

(Was parental consent given?)

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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(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.)

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

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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(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	<input type="checkbox"/>	NO	<input type="checkbox"/>
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(Please tick relevant box)

(If yes, please give details)

3.23 Did you experience any beneficial reaction?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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(Please tick relevant box)

(If yes, please give details)

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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	<input type="checkbox"/>	NO	<input type="checkbox"/>
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(Please tick relevant box)

(If yes, please give details)

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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	<input type="checkbox"/>	NO	<input type="checkbox"/>
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(Please tick relevant box)

(If yes, please give details)

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PART IV

GENERAL

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)

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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(Please tick relevant box)

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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)

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4.4 Please provide any other information that you think relevant:

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Signature: _____

Date: _____

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

Signature: _____

Date: _____

National Childhood Immunisation (Vaccination) Programmes	Date of Introduction
Diphtheria/Tetanus (DT)	1930s
BCG (to protect against tuberculosis)	1949
Diphtheria/Tetanus/Pertussis (DTP)	1952/3
Polio	1957
Rubella	1971
Measles	1985