

**Districts wise Summary of Death Audit report (2023-24)**

S.No	Name of the State	Name of the District	S.No.	Name of the deceased client	Age	Sex	Date of operation	Type of Facility where operation was conducted ((PHC/CHC/DH/Medical college/Accredited PVT/NGO Facility)	Fixed day/Static	Type of Procedure (Minilap/Abdominal tubal ligation/Laparoscopic/Conventional Vasectomy/NSV)	In case of Post Partum Sterilization specify if the delivery was Cesarean or normal delivery	If Post abortion specify the trimester in which the abortion was done	Whether Written consent obtained? (Y/N)	Atropine used in preanaesthetic medication (Y/N)	Anesthesia used (LA/GA)	Empannelled Provider (Y/N)	Date of death	Time of death	Place of Death (Health Facility, Home, on-way to hospital/home)	Any Post Operative complications (Y/N)	If yes, Write the Signs/Symptoms	Under-lying/Primary cause of death	Death audited By DISC(Y/N)	Action Taken
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Nil