Pan-Lancashire Child Death Overview Panel
Annual Report 2017-18

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Contents

Foreword

This is the first Annual Report I have been involved in since stepping down as CDOP Chair in March 2016, and taking up the role of interim Independent Chair in October 2017. The report comes at a time of tremendous change in terms of Safeguarding and the Child Death Review processes where responsibility for child death reviews will move to the Department of Health from the Department for Education, which retains responsibility for children's safeguarding arrangements. Whilst I welcome this change, I also recognise the importance of continuing the development of well-established relationships with the children's safeguarding partners. At the time of writing, we are still awaiting details about how this transfer will take place and the potential implications that this will have on the workings of CDOP.

I see part of my role as ensuring that the current processes we have developed Pan-Lancashire are robust and fit for purpose, and provide the necessary assurances to the current and future safeguarding partners and arrangements, irrespective of how they are organised, and within the resources available.

Introduction

This is the tenth annual report since Child Death Overview Panels (CDOP) became statutory in April 2008 and the sixth as a pan-Lancashire Panel. The pan-Lancashire CDOP is a sub-group of the three Local Safeguarding Children Boards (LSCBs) and has a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding infants live-born following planned, legal terminations of pregnancy) resident within the three Local Authority areas of Blackpool Council; Lancashire County Council (LCC) and Blackburn with Darwen (BwD) Council.

This report provides information on trends and patterns in child deaths reviewed:

- during the last reporting year (2017-18)
- over the last five years (2013-18)

It also makes overarching and individual recommendations to the three LSCBs based on the analysis.

Members and Attendance

During 2017/18 the CDOP had representation from Lancashire Constabulary, the Sudden Unexpected Death in Childhood (SUDC) Service, Children's Social Care, the three LSCBs, Community Health Services, Midwifery, Paediatrics, Clinical Commissioning Groups, Public Health, Neonatology & Obstetrics (co-opted for review of early neonatal deaths) and Education and Early Years representatives were provided by LCC, Blackburn with Darwen Council, and Blackpool Council respectively.

In an attempt to ensure equal representation across the three areas a rota system has been utilised for case discussion meetings which aims to ensure:

1. All three areas are represented
2. All agencies are represented
3. It is equitable for all: number of meetings attended is based proportionately on number of child deaths per area

The table below documents the attendance by each agency/ area of expertise for business and case discussion meetings.

Business Meetings (6 meetings)-To be completed		**Case Discussion Meetings (6 meetings)**		**Neo-natal Review Meetings (5 meetings)**	
Agency	**% Attendance**	**Agency**	**% Attendance**	**Agency**	**% Attendance**
Chair*	3 (50%)	Chair	2 (33%)	Chair	2 (40%)
Lancashire Constabulary	6 (100%)	Lancashire Constabulary	6 (100%)	Lancashire Constabulary	5 (100%)
Children's Social Care	5 (83%)	Children's Social Care	4 (67%)	Children's Social Care	3 (60%)
Public Health	6 (100%)	Public Health	6 (100%)	Public Health	5 (100%)
Lead Nurse for SUDC	5 (83%)	Named Nurse for Safeguarding	5 (83%)	Named Nurse for Safeguarding	5 (100%)
SUDC Prevention Chair	3 (50%)	Named Midwife	4 (67%)	Named Midwife	4 (80%)
Paediatrician	6 (100%)	Paediatrician	6 (100%)	Paediatrician and/or Neonatologist	5 (100%)
B'pool LSCB Business Manager	5 (83%)	SUDC Service	6 (100%)	SUDC Service	5 (100%)
BwD LSCB Business Manager	5 (83%)	Education (School/ Early Years Rep)	4 (67%)	Neonatal Specialist	0 (0%)
Lancs LSCB Business Manager	5 (83%)	Observers	9	Observers	5
CCGs	6 (100%)				
LCFT	6 (100%)				

Table 1, the attendance by each agency/ area of expertise for business and case discussion meetings

67% of business meetings had all geographical representation, with a member from each area being in attendance at each meeting. Additionally, throughout the reporting year the Panel has had 14 observers. Most of these observers attended the case discussion meetings with 5 observing the neonatal case discussion meetings. *The Independent Interim Chair of Pan-Lancashire CDOP took up post in October 2017 which explains the inconsistent attendance across the year.

CDOP priorities for 2017/18

Year	**CDOP Priority**	**RAG Rating**	**Comments-To be completed**
	CDOP Database		The CDOP database went live in January 2017 and is kept on the work programme for the CDOP business members to monitor in case of any problems. The database continues to be a success with more updates and bug fixes

			being released by QES, the database company. Form B returns by agencies are becoming more detailed and within the three week statutory deadline. The community services remain one of the best agencies in completing forms on time and in detail.
	Implement and oversee the proposed changes of the SUDC Service		The extension of the SUDC Service was agreed and the SUDC Steering Group was established to oversee the proposed changes. For further information please see the section on page 7 under SUDC Service update.
	To implement to recommendations from the ACE audit		The ACE audit was ongoing at the time of writing the report and is due to be presented to the June CDOP business meeting. This action will be rolled over to 2018/19
	To scope out under taking further thematic reviews into deaths due to infection and death due to trauma and other external factors.		Two reviewers were identified and have completed their audits of the CDOP cases. Both reports are due to presented to CDOP business members later on in 2018.
	Engagement with GPs		Engagement with GPs is still ongoing. This will be rolled over to 2018/19.

Table 2, update on CDOP priorities for 2017/18

2016/17 Annual Report Recommendation Update:

Lancashire LSCB:

- Identify a suitable education representative to sit on the CDOP

Update: This recommendation is in progress as Lancashire LSCB had been waiting for a new staff member to take up post before a person could be identified. It is agreed that a member will be on the rota from next year.

Pan-Lancashire LSCBs:

- LSCB members are to reiterate to all agencies about their statutory responsibility of returning Form Bs within timescale as this can put a delay in the CDOP process

Update: This recommendation was noted at the three LSCB meetings when the annual report was presented. The database now assists with this issue by sending out reminders when forms are due.

- Pan-Lancashire LSCBs to make a recommendation to the pan-Lancashire Suicide Prevention Strategy Group that they link in with and include CDOP data in future analysis

Update: This recommendation was taken to the pan-Lancashire Suicide Prevention Group and CDOP are now a member of the group.

- The LSCBs and Health and Wellbeing Boards should take note of the modifiable factors identified, especially around smoking and alcohol/substance misuse and assure themselves

that they have effective mechanisms in place to measure the impact of the services delivered that address these

CDOP Key Successes 2017/18

CDOP Conference 'Make Every Contact Count'

In May 2017 the SUDC Prevention Group hosted the 'Make Every Contact Count' conference. The aim of the conference was to assist frontline practitioners in preventing infant deaths and to give practitioners more confidence when delivering safer sleep messages to parents and to also challenge parents regarding safer sleep arrangements. The aim of the conference was to also provide information about what happens when a child dies and how they are investigated. Various professionals from across Pan-Lancashire presented including the SUDC team, members from Public Health, LCFT, Lancashire Constabulary and the Blackpool Coroner. The theatre group 'AftaThought' delivered two live performances around infant deaths and safer sleep which were very powerful. The conference was well attended with over 120 delegates in attendance and received excellent feedback, some of which can be found below. A full evaluation is available upon request.

"I found the whole day extremely interesting. I particularly enjoyed the 'AftaThought' scenes. These were very powerful and gave attendees some subtle messages on how they could change practice".

Safer Sleep Campaign:

The Campaign has continued to supply professionals with materials to support them in providing consistent messages to parents/ carers across pan-Lancashire. For the third year running a bulk order of the materials was placed with regional colleagues (Pan-Cheshire and Merseyside CDOPs). This significantly reduced the cost for pan-Lancashire and provided regionally consistent messages and reduced cross-border differences particularly for acute trusts.

Positive Recognition:

In order to recognise and encourage good practice, or where agencies have gone above and beyond their expected duties, CDOP send letters of good practice. Whilst it is the panel's responsibility to identify learning and trends from child deaths across pan-Lancashire, the panel feel it is important to recognise the excellent care that professionals provide for the children and families that they work with.

Sector Led Improvement:

Pan-Lancashire CDOP actively participated in the North West Directors of Public Health Sector Led Improvement programme on child deaths under one year old. CDOP provided information along with other areas across the NW, and a follow-up action plan was developed.

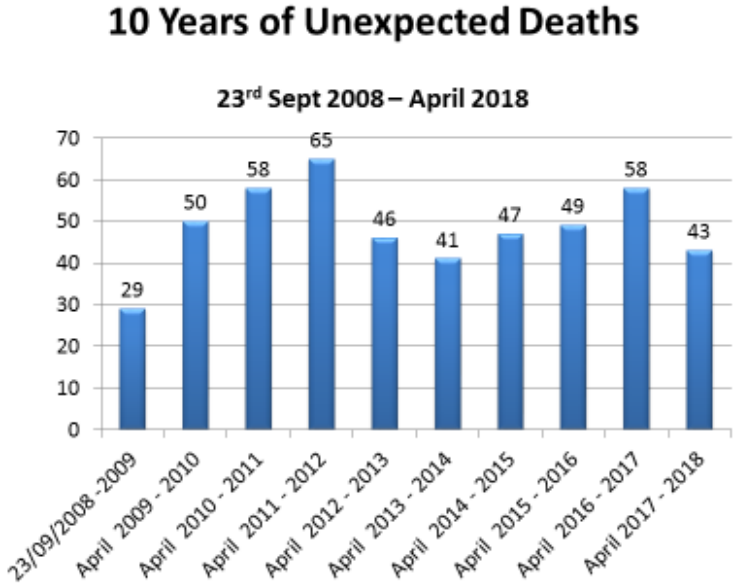
CDOP Sub Group Updates:

SUDC Service

The Sudden Unexpected Death in Childhood (SUDC) service is a unique Nurse-led Service that has provided the health element of the Pan- Lancashire multi-agency rapid response process to a sudden, unexpected death of a child since September 2008. The service responds to approximately 1 death per week providing a bespoke service that exceeds statutory requirements. The Service is

hosted by Lancashire Care Foundation Trust and currently consists of two Senior Nurses, a Lead Nurse and a Specialist Nurse. One of the main aims of the commissioned Lancashire SUDC team is to ensure that any unexpected child death receives a multi-agency coordinated response; in addition to, leading on the response from a health perspective (fulfilling the role of the Designated SUDC Paediatrician described in Working together to Safeguard Children 2015)

Since the inception of the service the number of unexpected deaths that the service has responded to each year has remained consistent, however, this year has seen a slight decrease in the number of deaths responded to. This is almost the lowest number of deaths Pan Lancashire recorded to date. As last year, many of the deaths responded to have a significant safeguarding element to them thereby raising the complexity of the response and subsequent processes.



Service Development

The service has continued to develop and modernise in response to changes within the NHS and partner organisations. The first service review was carried out in August 2016, this recommended changes for further improvement and development. The SUDC team in partnership with commissioning colleagues has explored the most efficient and cost effective provision of the service, which will also improve support for the family from the outset.

In response, the service is currently in the transition process of progressing to a 7-day working model in order to improve equity of responses, thereby, enriching the SUDC investigation by providing SUDC Nurse input from the outset for an increased number of cases. Compliance with the Kennedy Principles (2016) will also be improved.

It is anticipated that the 7-day service will be operational by November 2018.

Rapid responses

Total number of unexpected death notifications for 2017- 2018 = 43

Locality	Number of deaths (2016/17 figures in brackets)
Blackpool	<5 (<5)
East Lancashire	15 (17)
North Lancashire	8 (8)
Central Lancashire	6 (17)
BwD	8 (12)
Out of area	<5

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Compliance

The service continues to monitor the times that deaths occurred. This year the SUDC service has responded to almost half of the deaths (**21**) from the outset, (**9** of the deaths occurred at the weekend with the remainder (**12)** having a single agency response where the SUDC Nurse responded on the next working day.

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Complex cases

17 of the deaths either were known or required Children's Social care involvement requiring Strategy meetings with some with ongoing referrals for SCR (**5**) consideration or continuing criminal proceedings (<5), **7** of the deaths involved parents who were known to have domestic abuse as a feature of their relationship.

Themes

<u>Unsafe sleep</u>

This year has seen a further decrease in the number of deaths where unsafe or inappropriate sleeping arrangements had been a feature (**5**).

2016-2017 **(8)**

2015-2016 **(13)**

Over the last four years, there have been 37 child deaths where unsafe or inappropriate sleeping have been a contributory factor.

Suicide

Hanging continues to be a theme. There have been five notifications of death by hanging this year. <5 of these deaths occurred in the North of the county. There have been 10 'suicide' deaths in total since 2016. In response, CDOP is to commence a suicide thematic review in collaboration with South Cumbria, working with the Lancashire and South Cumbria Suicide Logic Prevention Group.

The SUDC team will be an integral part of this review, which will make recommendations to partner agencies and the Pan Lancs LSCBs. As part of this work, CDOP will also link in with other CDOPs across the country to identify any common themes and trends and will routinely collect information on Adverse Childhood Experiences (ACEs). See Appendix 2.

Additionally, CDOP will continue to sit on the Lancashire and South Cumbria Suicide Logic Prevention Group, it is hoped by linking in with this group that more agencies will become aware of CDOP and the SUDC service and the work that they undertake.

Other cases involving a SUDC response

<5 deaths involved children who were 'Looked After'
10 deaths suffered from an underlying known health condition/complex medical need
<5 neonatal deaths
<5 of the deaths were as a result of meningococcal septicaemia,
<5 deaths were as a result of an accident
<5 deaths following a road traffic collision

Training

The SUDC Nurses have worked with the Pan Lancashire Safeguarding Boards to refresh multi-agency training. The aim of the sessions is to raise awareness of the Pan Lancs SUDC Protocol and include some anonymised cases in relation to Safer Sleep messages. 4 sessions are planned for the forthcoming year.

Multi-agency working

In order to improve partnership working with police colleagues, the **Pan Lancashire Child Death Investigation Group (CDIG)** has been established. It is anticipated that this group will provide a structured forum where the Detective Inspectors and SUDC Team are able to meet monthly. The terms of reference agreed are:-

- To promote best practice in child death investigations
- To promote staff development in the field of child death investigations
- To ensure effective multi agency responses to incidents of Sudden Unexpected Child Death in Childhood and Infancy

In addition, the SUDC Team now meet with acute and Community Pan Lancs Named Nurses on a quarterly basis. The main aim of this group is to address any issues arising

from SUDC responses but also communicate relevant and up to date information in relation to unexpected child deaths to frontline professionals who may be involved

SUDC Prevention Group

The SUDC Prevention Group is coordinated by the pan-Lancashire CDOP and is funded by the CDOP budget (£15,000) and contribution from LCC Public Health when required. The funding maintains the supply of materials to agencies pan-Lancashire and in 2017/18 funded a re-order of safer sleep materials. In 2016/17 the SUDC Prevention Group undertook the 'Make Every Contact Count' Conference, this is detailed above on page 6. As part of strengthening the group's priorities members led by the chair, devised a strategic plan to ensure that the group were meeting their priorities and objectives.

CDOP Priorities for 2018/19:

- ✓ Deliver the SUDC Prevention group priorities including:
  - Maintaining a supply of materials to agencies pan-Lancashire
  - Promoting the safer sleep campaign through pharmacies in Autumn 2018
  - Developing the intergenerational campaign for the safer sleep messages
  - Auditing the safer sleep materials
  - Assisting Rochdale CCG with the do not shake the baby campaign
- ✓ Manage a smooth transition of the Child Death Review process from Local Safeguarding Boards to new governance arrangements
- ✓ Ensure that the new guidance is implemented including:
  - Ensuring all child death review meetings (e.g.perinatal mortality; hospital mortality; etc) inform the CDOP process in a standardised/ structured manner
  - Implementation of any changes to the reporting processes e.g. Forms A, B, C
- ✓ Ensure all agencies understand the new guidance and relevant processes
- ✓ Consider further analysis of the observed disproportionate Blackburn with Darwen deaths in certain population groups, and feedback to the LSCB and other partners (Page 15)
- ✓ Collect and report on Adverse Childhood Experiences as they relate to Pan-Lancashire deaths, and liaise with NHS England and the National Database on future collection of this data at a national level

Recommendations:

LSCBs to:

- ✓ Note the content of this report
- ✓ Support the priorities for 2017/18 identified above

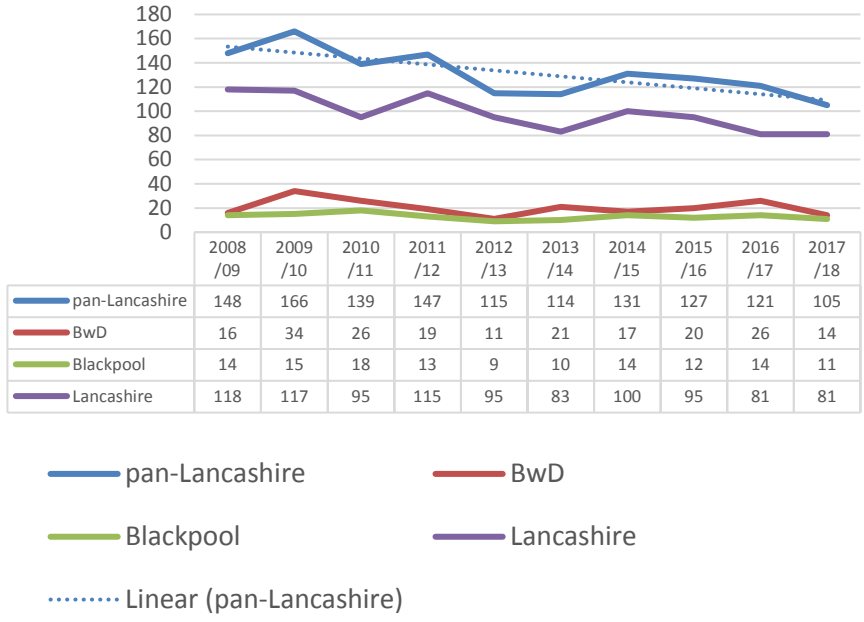
Part 2 – Data Analysis

Summary of the cases notified to panel between April 2017 and March 2018.

This section of the report considers data pertaining to notifications received and cases reviewed by the panel between April 2017 and March 2018 only.

During the 2017/18 reporting year, CDOP was notified of 105 child deaths (11 Blackpool residents, 14 Blackburn with Darwen (BwD) residents and 80 Lancashire residents) which were in line with Working Together to Safeguard Children (2015) definition and therefore considered by the pan-Lancashire CDOP. 14 additional notifications were outside the statutory guidance and therefore not reviewed including 10 cases out of area (reviewed by the CDOP in their area) and <5 terminations of pregnancy.

Figure 1 : Number of Child Death Notifications 2008-18

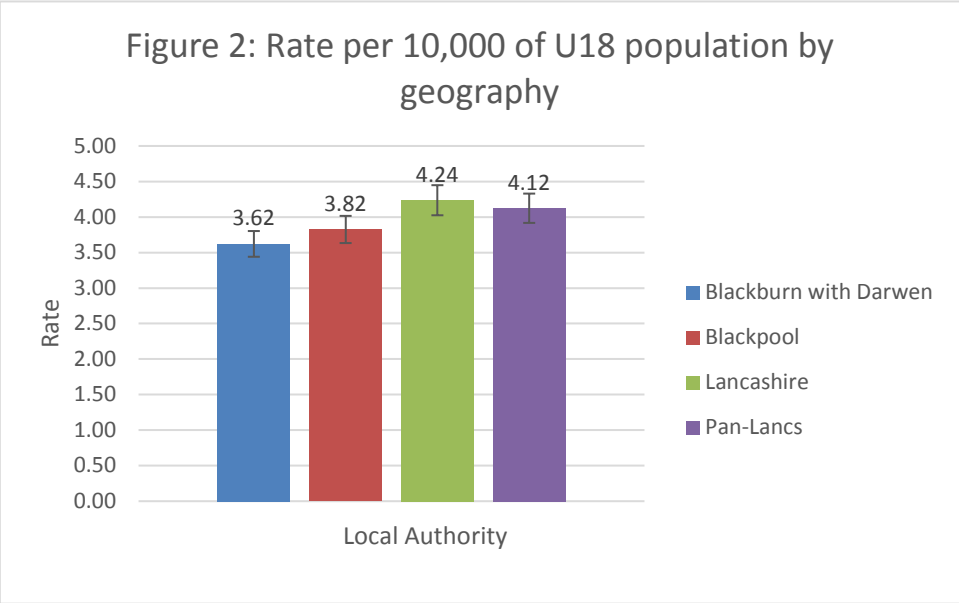


	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
pan-Lancashire	148	166	139	147	115	114	131	127	121	105
BwD	16	34	26	19	11	21	17	20	26	14
Blackpool	14	15	18	13	9	10	14	12	14	11
Lancashire	118	117	95	115	95	83	100	95	81	81

Figure 1 below shows the number of statutory notifications received in each reporting year since CDOPs became statutory in April 2008.

Overall, from 2008 there has been a gradual downward trend in the number of reported deaths across Pan-Lancashire. The 2017/18 reporting year has seen the lowest number of deaths notified to CDOP to date. Both Blackpool and BwD have seen a decrease in the number of notifications, with BwD in particular seeing a fall from 26 being notified to CDOP in 2016/17 to 14 being notified in 2017/18.

Similarly, if we look at the proportion of notifications compared to the relevant under 18 population for each area (Figure 2), we can see that both Blackpool and Blackburn with Darwen have lower rates, despite their well established, higher indices of multiple deprivation (IMD). This may be explained by relatively small numbers in the two Unitaries, where annual fluctuations can create larger fluctuations in rates. CDOP will keep an eye on any emerging trends, but it is not felt necessary for further analysis at this point in time.

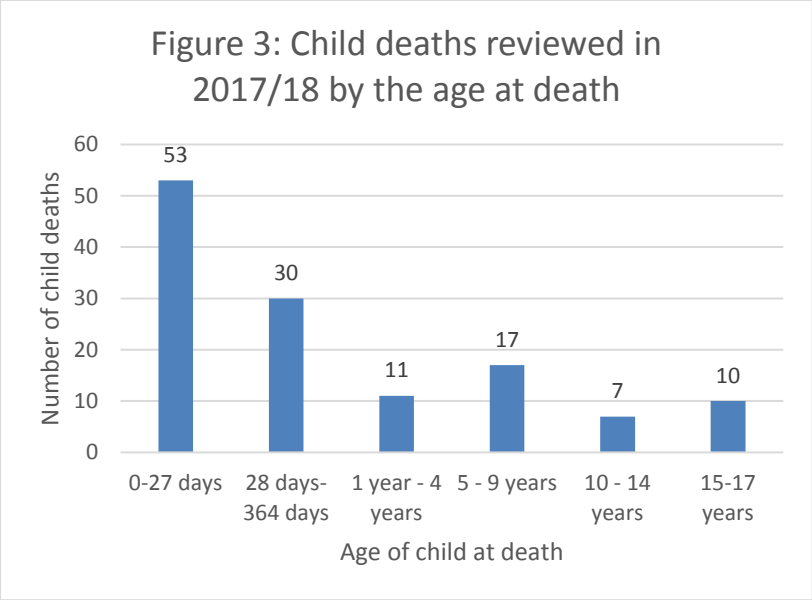


Analysis of reviews undertaken by the panel April 2016 to March 2017

In the reporting year ending March 2018, the Panel completed 128 reviews (23 BwD reviews, 11 Blackpool reviews and 94 Lancashire reviews) compared to, 97 reviews in 2016/17. Of the 128 completed this year 71 were expected deaths, 50 were unexpected and 7 were unexpected but meeting exclusion criteria.[1]

[1] Where a child dies within 24 hours of birth or shortly thereafter **and** has never left hospital **and** there is a clear medical explanation for the death, falls within the exclusion criteria for a Rapid Response. Any death that falls within this criteria is unexpected but a rapid response is not required.

Child Death Reviews by Age



The pattern of reviews completed by age seen in figure 3 (above) is similar to that seen nationally. Of the deaths reviewed, the highest number of deaths occurred in children under one year of age (65%).

As part of an approach to prevent infant mortality across the North West region, CDOP continues to contribute to the North West Sector Led Improvement (SLI) Infant Mortality plan. In November 2017 the CDOP administration team, members from Public Health from across Pan-Lancashire and the SUDC team attended the North West Infant Mortality Conference where a number of presentations and workshops were held which looked at factors that contribute to infant mortality. CDOP members will continually work collaboratively to ensure good practice is shared.

Child Death Reviews by Ethnicity

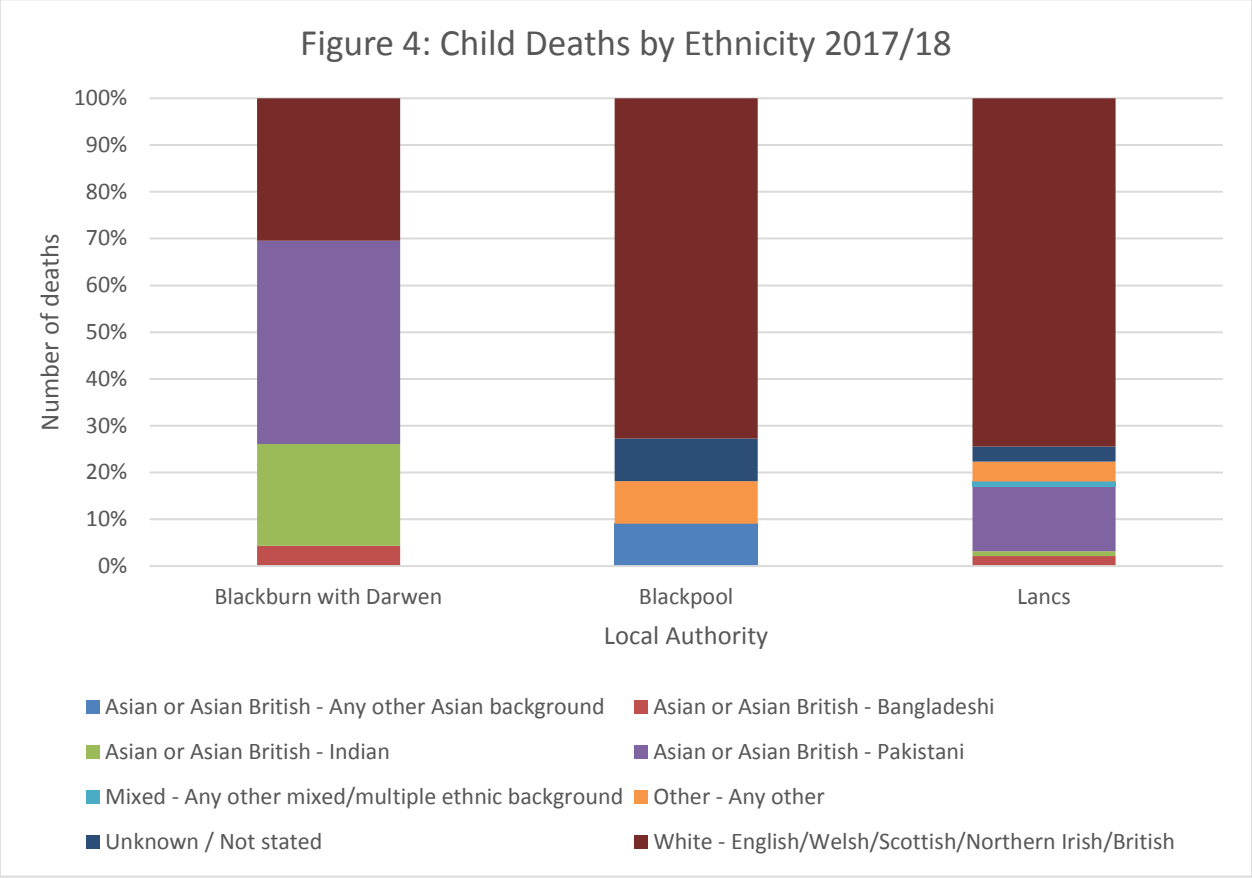


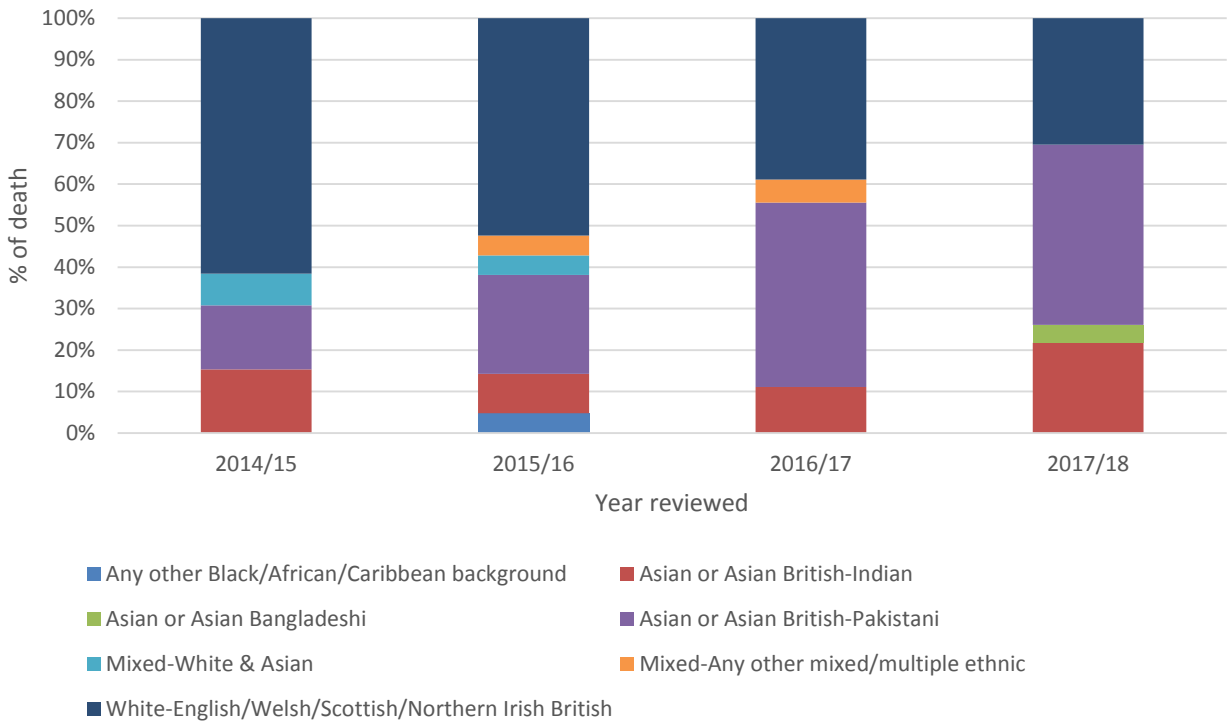
Figure 4 (above) reflects the diversity of the county and highlights that, of the cases reviewed in 2017/18, the majority of deaths for Lancashire were White-English/Welsh/Scottish/Northern Irish/British making up 73% of the total number. 17% of the Lancashire deaths reviewed were children of Asian/Asian British Pakistani heritage and based on the 2011 census the population for Lancashire was 5.7% meaning that the Asian Pakistani ethnicity is over represented in the child death data. This is a trend seen each year.

Of the Blackpool deaths reviewed, 73% were of White-English/Welsh/Scottish/Northern Irish/British.

Of the BwD deaths reviewed, 43% were of Asian or Asian British Pakistani heritage and 26% were White British. Again, based on the information from the 2011 census the child population (0-17) for BwD consists of 54% White British children and 18% Asian or Asian Pakistani children, which indicates that this number is disproportionately higher compared to the census data.

When comparing previous annual reports, in 2016/17 the number of Asian or Asian British Pakistani heritage deaths was 44%, meaning that the numbers remain similar to the last reporting year. However, it should be noted that in 2015/16 there was an observed rise in the number of Asian or Asian British Pakistani deaths reviewed (figure 5 below). This may require further analysis.

Figure 5: BwD Child Death Reviews by Ethnicity 2014-18



Category of Death

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The most common category of death across pan-Lancashire for cases reviewed during 2017/18 was chromosomal, genetic and congenital anomalies (29%) with the second most common category of death being perinatal/neonatal event (27%). This is consistent with England and Wales where perinatal and congenital causes are the most common, especially in neonates. It is the third time since 2008 that chromosomal, genetic and congenital anomalies have been the most common category of death. There has been a slight increase in deaths due to malignancy but it should be noted that there has been a higher number of deaths reviewed by CDOP this reporting year.

Figure 7 (below) shows the category of death broken down into year reviewed. As can be seen chromosomal, genetic and congenital anomalies (dark blue) and perinatal/neonatal event (maroon) are by far the biggest categories with the other categories remaining fairly consistent across the years.

Figure 7: Category of death by year reviewed 2008-18

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Location of death

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Figure 8 highlights that the majority of children die within a hospital setting (84%). This is expected due a large proportion of deaths being related to neonatal and perinatal events, and chromosomal, genetic and congenital anomalies, which require medical support.

Modifiable Factors

A modifiable factor is defined as "*one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths*" (Working Together, 2015).

	Expected Deaths		Unexpected Deaths (including unexpected meets exclusion criteria)		
Local Authority	**Modifiable Factors**	**No Modifiable Factors**	**Modifiable Factors**	**No Modifiable Factors**	
BwD	<5	10	<5	7	
B'pool	0	7	<5	<5	
Lancashire	14	38	20	22	
Pan-Lancashire	16	55	26	31	

Table 4: Total number of deaths reviewed in 2017/18 by expected/unexpected and whether modifiable factors were identified, one death in Lancashire had insufficient information and could therefore not be categorised.

The table above identifies the number of deaths reviewed in 2017/18 by the child's local authority that were considered to have modifiable factors and whether the deaths were expected or unexpected. During 2017/18 33% of cases reviewed pan-Lancashire (42) had modifiable factors identified, compared to the 2016/17 reporting year 37% of cases reviewed had modifiable factors. This is a slight decrease from last year. The most common modifiable factors identified in 2017/18 across pan-Lancashire were smoking by parent/carer in the household (44%) and unsafe sleep (27%) (Including co-sleeping, temperature of room and unsafe sleeping surfaces).

Category of death and Modifiable Factors

Of the cases reviewed, the largest category of death pan-Lancashire in 2017/18 with modifiable factors was perinatal/neonatal events (33%). The second largest category to have modifiable factors was trauma and other external factors (17%) with sudden unexpected, unexplained deaths being the third largest category (14%). There were no modifiable factors for deaths caused by malignancy.

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Figure 9, category of the child's death as defined by the Department for Education and whether modifiable factors were identified in reviews completed between April 2017 and March 2018

Category of death by local authority and modifiable factor

Category	Blackburn with Darwen	Blackpool	Lancashire	
	Modifiable Factors			Pan-Lancashire Total
Deliberately inflicted injury, abuse or neglect	0	0	<5	<5
Suicide or deliberate self-inflicted harm (2)	0	0	<5	<5
Trauma and other external factors (3)	<5	<5	<5	7
Malignancy (4)	0	0	0	0
Acute medical condition (5)	0	0	<5	<5
Chronic medical condition (6)	0	0	<5	<5
Chromosomal, genetic and congenital anomalies (7)	0	0	<5	<5
Perinatal/neonatal event (8)	<5	0	10	13
Infection (9)	0	<5	<5	<5
Sudden unexpected, unexplained death (10)	<5	0	<5	6

Table 5: Category of death by local authority and modifiable factor

As previously mentioned, the most common category of death to have been deemed to have modifiable factors across Pan-Lancashire is perinatal/neonatal events and this is evident in the Blackpool and Lancashire figures. Due to such small modifiable factors being identified in BwD there was not one common category. The second most common category of death across Pan-Lancashire was trauma and other external factors. However, it should be noted that <5 of these were Lancashire deaths. As these numbers are so small they should be treated with caution.

Length of time to complete the review-to be completed

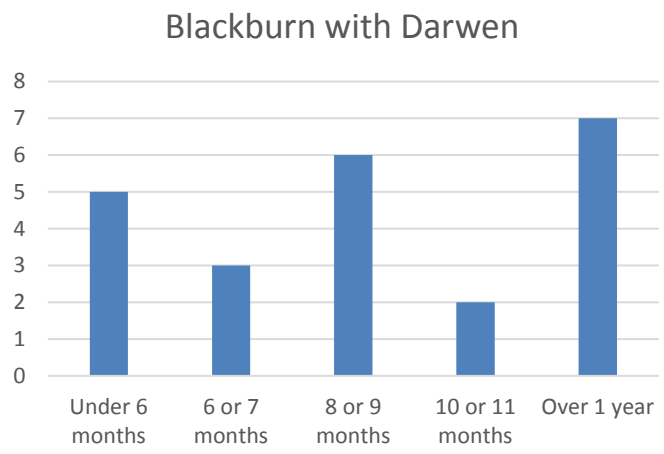

Figure 10, Time taken to complete reviews, BwD

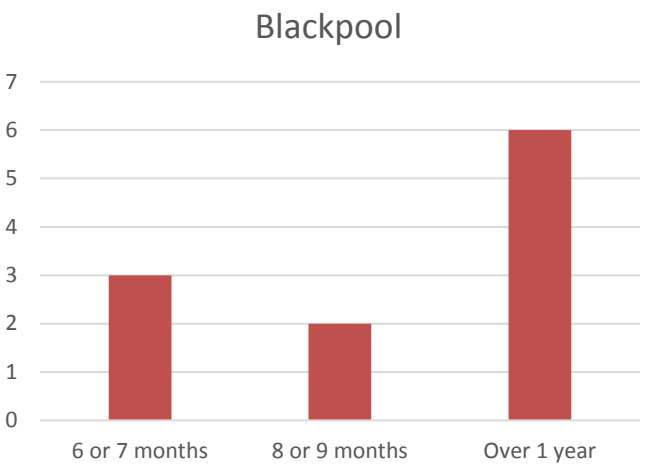

Figure 11, Time taken to complete reviews, Blackpool

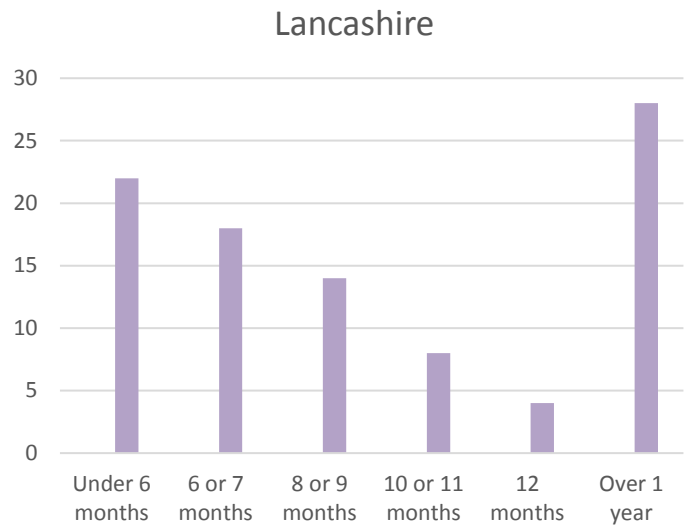

Figure 12, Time taken to complete reviews, Lancashire

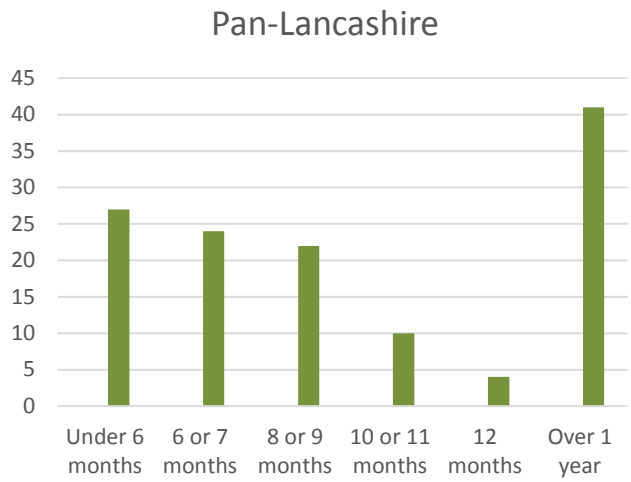

Figure 13, Time taken to complete reviews, Pan-Lancashire

The CDOP is expected to review all deaths within a reasonable length of time, although the length of time varies depending on several factors, particularly if there is a criminal case involved. Of the deaths notified to panel in 2017/18, several were subject to serious case reviews and ongoing investigations that delays cases being reviewed. The CDOP will continue to monitor how many cases it completes. However, this is subject to practitioners completing Form Bs within the statutory three week timescale. Form Bs returned after this timescale can delay cases being taken to panel.

Appendix 1 - Department for Education category of death descriptions

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	☐
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	☐
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect. (category 1).	☐
4	**Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	☐
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	☐
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	☐
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease,cystic fibrosis, and other congenital anomalies including cardiac.	☐
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, eg sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	☐
9	**Infection** Any primary infection (ie, not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	☐
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	☐

Appendix 2: Recognised Adverse Childhood Experiences (ACEs) and definition

ACE	Definition
Physical abuse	Intentional use of physical force against a child that results in, or has the potential to result in, physical injury.
Sexual abuse	Any completed or attempted sexual act, sexual contact with, or exploitation of a child by a caregiver.
Emotional abuse	Intentional caregiver behaviour that conveys to a child that they are worthless, flawed, unloved, unwanted, endangered, or valued only in meeting another's needs
Neglect	Failure by a caregiver to meet a child's basic physical, emotional, health, or educational needs—or a combination of these.
Domestic violence	Any form of verbal or physical violence between a caregiver and his or her adult partner or ex-partner
Parental separation	Divorce or separation between parents or caregivers
Substance misuse	Living with a parent, caregiver or other family member who misuses substances, including illegal drugs and prescription medications
Alcohol misuse	Living with a parent, caregiver or other family member who misuses alcohol
Mental health issues	Living with a parent, caregiver or other family member who is depressed, has other mental health problems or has ever attempted suicide
Incarceration	Living with a parent, caregiver or other family member who sentenced to serve time in a prison or youth offending institution