



# Confidential Enquiry into Maternal and Child Health

*Improving the health of mothers, babies and children*

## Child Death Review

### Assessment of Contributory Factors

Case number:

The confidential enquiry panel seeks to identify contributory factors that might have relevance to the death of the child.

This pro forma is designed to help panels work through the relevant issues in a structured fashion, and to make judgments about the importance of any factors that they discover, and based on these, to classify the death in terms of avoidability. We suggest that following a short presentation of the case, the panel work through the pro forma after first familiarising themselves with its structure.

- **Section A** asks the panel to identify the location of the death, and/or the place where the injury or accident occurred.
- **Section B** asks the panel to identify and score factors extrinsic to the child.
- **Section C** asks the panel to identify and score factors intrinsic to the child.
- **Section D** asks the panel to identify those agencies or agents directly and indirectly involved with the care of the child, and to score their contribution to any avoidable factors.
- **Section E** asks the panel to consider the health care of the child, in situations where there was the possibility that different medical intervention might have saved the child's life.
- **Section F** asks the panel to assess the impact on their own deliberations of any important omissions in the documentation.
- **Section G** asks whether the panel had access to the result of any local case review.
- **Section H** asks the panel to identify areas of good practice.
- **Section I** asks the panel to consider the findings of the post-mortem examination.
- **Section J** asks the panel to state the extent to which their own findings enhance information from death certification.
- **On the Summary Page**, the panel is asked to summarise the circumstances in no more than three sentences, to highlight any cross-agency factors such as poor communication; and to highlight learning points and recommendations.
- The panel is finally asked to categorise the death according to their estimation of its avoidability, taking all the previously assessed contributory factors into account.

---

**SECTION A**  
**The location of the death, and/or the accident or serious illness  
immediately leading up to the death of the child**

---

This refers to the physical place where the event happened, in relation to accidents and injuries that proved lethal either immediately or subsequently. For example, if a child falls in the sea but dies subsequently in hospital from near-drowning, the relevant location for this section is the sea, not the hospital.

**Please select one of the following 5 options:**

**1. Domestic environment**

This refers to a house, apartment, or garden of a house belonging to, or lived in by, the child's family, or friends, or relatives; or the young person's own residence. *Specify also who was giving the childcare in this location (eg nanny, childminder, parent, relative etc).*

If applicable to this child, please specify:

**2. School or nursery**

This refers to either the indoor or outdoor facilities of a school, college or nursery (ie buildings, playgrounds and sports fields)

If applicable to this child, please specify:

**3. Health service facility**

This includes hospitals (NHS or private), GP surgeries, dental practices, and hospices, where the child died or where an event that proved fatal occurred.

If applicable to this child, please specify:

**4. Other institution**

This includes any other institutional facility such as prison, remand centre, detention centre, police station, facility of the armed services.

If applicable to this child, please specify:



**5. Other place**

This includes all other places: public spaces or places (shops, restaurants, malls etc); places of public entertainment; leisure facilities and public swimming pools; public or private transport; roads, railways, airports, rivers and canals; the sea, and commercial or private shipping; the countryside including farmland and farm buildings; properties open to the public; etc.

**If applicable to this child, please specify:**




---

**SECTION B**  
**Environmental (extrinsic) factors**

---

This section allows the panel to consider environmental factors extrinsic to the child that may have had a bearing on the events leading up to the death, and the strength of its contribution. For example, when a teenager died of hypothermia when walking home in a snow blizzard, the weather was scored 4.

Score the assessed contribution of environmental factors as follows:

- 0 The factor is known to be present, but not relevant to the death
- 1 Probably a minor or background factor among the events leading up to the death
- 2 Probably a significant factor among the events leading up to the death
- 3 Probably a major factor, but one of several others impacting on the death
- 4 Directly and overwhelmingly important factor in the death
  
- 6 The factor is known to be present, but contribution cannot be estimated
- 7 Documents available to panel confirm that factor was not present
- 8 Documents available to panel do not state whether or not the factor was present
- 9 Not applicable to this child

- |  |  |
|--|--|
| <b>1. Weather</b>  | <b>Score:</b> <input type="checkbox"/> |
| <b>2. Absence or failure of barrier or safety device<br/>(fence, door, window, safety barrier, smoke alarm etc.)</b> | <b>Score:</b> <input type="checkbox"/> |
| <b>3. Absence or failure of in-vehicle restraints</b>  | <b>Score:</b> <input type="checkbox"/> |
| <b>4. Road hazard<br/>(consider <i>all</i> factors relating to the road and any vehicles)</b>                        | <b>Score:</b> <input type="checkbox"/> |

**5. Other extrinsic factor(s)**

Specify other factors, and score their contribution.

These could include errors in judgement or decision-making by adults or agencies; harm from persons under the influence of drugs or alcohol; public transport disasters; 'freak' accidents like gas explosions; household violence; homicide; terrorist attacks; aspects of infant care related to infant death; one or more manifestations of 'deprivation'; food poisoning, etc.

If the parent or carer had been using alcohol or drugs, this may be a relevant extrinsic factor.

There may be extrinsic factors specific to the location of the accident or serious illness leading up to the death.

Factor	Score
1. _____	<input type="checkbox"/>
2. _____	<input type="checkbox"/>
3. _____	<input type="checkbox"/>
4. _____	<input type="checkbox"/>
5. _____	<input type="checkbox"/>
6. _____	<input type="checkbox"/>

---

**SECTION C**  
**Personal (intrinsic) factors**

---

This section allows the panel to consider intrinsic factors relating to the child that may have had a bearing on the events leading up to the death, and the strength of its contribution. For example, when a sixteen year old died of hypothermia when walking home in a blizzard, her inappropriate clothing scored 4; and the fact that she had been drinking scored 3.

Score the assessed contribution of personal (intrinsic) factors as follows:

- 0 Known to be present, but not relevant to the death
- 1 Probably a minor or background factor among the events leading up to the death
- 2 Probably a significant factor among the events leading up to the death
- 3 Probably a major factor, but one of several others impacting on the death
- 4 Directly and overwhelmingly important factor in the death
  
- 6 Known to be present, but contribution cannot be estimated
- 7 Documents available to panel confirm that factor was not present
- 8 Documents available to panel do not state whether or not the factor was present
- 9 Not applicable to this child

1. **Sensory impairment** (child had visual or hearing impairment, whether or not fully corrected with glasses or aids).

<b>Sensory impairment</b>	<b>Score</b>
1. _____	<input type="checkbox"/>
2. _____	<input type="checkbox"/>
3. _____	<input type="checkbox"/>

2. **Motor impairment** (this might be temporary or long standing, including cerebral palsy, delayed motor skills, or an immobilised limb due to fracture, etc)

<b>Motor impairment or physical disability</b>	<b>Score</b>
1. _____	<input type="checkbox"/>
2. _____	<input type="checkbox"/>
3. _____	<input type="checkbox"/>

3. **Learning difficulty or disability** (any identified problem that either requires, or required, placement in a special school, extra help within school, and/or a current statement of special educational need)

<b>Learning difficulty or disability – specify nature</b>	<b>Score</b>
1. _____	<input type="checkbox"/>
2. _____	<input type="checkbox"/>
3. _____	<input type="checkbox"/>



**SECTION C continued**

4. **Acute physical illness.** This relates to any physical illnesses whether or not they can directly lead to death, and the panel should score their contribution in this case. For example, a child may be known to have a cold but it scores 0, or a child may have 'flu, be off school with it, and die in a house fire at home, scoring perhaps 3.

<b>Acute physical illness</b>	<b>Score</b>
1. _____	<input type="checkbox"/>
2. _____	<input type="checkbox"/>
3. _____	<input type="checkbox"/>
4. _____	<input type="checkbox"/>
5. _____	<input type="checkbox"/>

5. **Chronic physical illness.** This relates to those long standing illnesses that the child or young person may have had. Obvious examples are diabetes and asthma, but include here any congenital anomalies, chromosomal disorders, perinatal diseases including brain injury, etc. The panel should note all such illnesses or conditions and score their contribution, if any, to the death.

<b>Chronic physical illness</b>	<b>Score</b>
1. _____	<input type="checkbox"/>
2. _____	<input type="checkbox"/>
3. _____	<input type="checkbox"/>
4. _____	<input type="checkbox"/>
5. _____	<input type="checkbox"/>

6. **Mental illness or behavioural problem.** Note any documented illness such as depression, other mental illness, or behavioural problems. This section includes attention deficit hyperactivity disorder and self-gratification behaviours such as partial asphyxiation. Score their contribution, if any, to the death

<b>Mental illness and/or behavioural problem</b>	<b>Score</b>
1. _____	<input type="checkbox"/>
2. _____	<input type="checkbox"/>
3. _____	<input type="checkbox"/>



**SECTION C continued**

7. **Presence of any drugs or alcohol in the child who died.** This might be 'social' ingestion, a possible attempt at self-harm, an accidental ingestion by a small child, or prescribed medication. List every identified substance and score for relevance to the death.

<b>Substance</b>	<b>Score</b>
1. _____	<input type="checkbox"/>
2. _____	<input type="checkbox"/>
3. _____	<input type="checkbox"/>
4. _____	<input type="checkbox"/>
5. _____	<input type="checkbox"/>

8. **Clothing.** Consider whether the child or young person was wearing clothing appropriate to their activity or the weather, including protective clothing such as helmet or hat, life jacket etc.

<b>Type of clothing or protective garment, including absence</b>	<b>Score</b>
1. _____	<input type="checkbox"/>
2. _____	<input type="checkbox"/>
3. _____	<input type="checkbox"/>

---

**SECTION D**  
**Agencies or agents involved with the child**

---

For each agency:

- Consider whether the agent or agency was **either** physically present with the child (direct involvement), **or** only indirectly involved (please score only one of these options);
- Consider the identification or awareness of hazard and risk, or lack of this;
- Consider the appropriateness of the agency's handling of the child in terms of timely involvement of other agencies or emergency services, evacuation, first-aid treatment or out-of-hospital medical care.

Score the assessed contribution of each relevant agency as follows:

- 0 Known to be present, but not relevant to the death
- 1 Probably a minor or background factor among the events leading up to the death
- 2 Probably a significant factor among the events leading up to the death
- 3 Probably a major factor, but one of several others impacting on the death
- 4 Directly and overwhelmingly important factor in the death
  
- 6 Known to be present, but contribution cannot be estimated
- 7 Documents available to panel confirm that factor was not present
- 8 Documents available to panel do not state whether or not the factor was present
- 9 Not applicable to this child

**1. 'Family'**

***Direct involvement***

Parent(s), Older sibling(s), Relative(s), Foster carer(s), other informal adult carer(s) substituting for the parents by arrangement, who are physically present with the child.

**Score**

***Indirect involvement***

Has family (as defined above), but no responsible member was physically present with the child at the time.

**2. Education**

***Direct involvement***

The child was at school, or engaged in an out-of-school activity where the responsibility for the child was provided by the school. This includes all types of educational provider.

**Score**

***Indirect involvement***

Education was indirectly involved with the child if the child was normally attending school or college (even if they were truanting), or receiving other formal educational input either at home or in specific pre-school provision. It would not apply to children who have left school, or not yet entered school, who are taught at home by parents, or the children of some itinerant families who do not attend school: these would score 9.

**3. Social Services**

***Direct involvement***

Where a child is at a social services nursery, or looked after in residential or secure social services accommodation, or resident in a family therapy hostel, or in a social service refuge for women from domestic violence; or when social services staff were providing direct personal care for a child.

**Score**

***Indirect involvement***

If the child or a member of the family was currently (at the time of serious injury or illness leading up to the death) part of a social service caseload.

**SECTION D continued**

**4. Health**

***Direct involvement***

This includes all inpatient care, including hospices and private healthcare facilities, or where the child is under the immediate physical care of a health professional (doctor, nurse, paramedic, physiotherapist, health visitor, community midwife etc) or other health professional outside hospital (eg palliative care at home); but not 'good Samaritan' care. If health issues are dominantly those of acute hospital admission, score this as 6 and score with those issues in detail in section E.

**Score**

***Indirect involvement***

This applies if the child was seeing a hospital consultant as an outpatient, a mental health professional (including psychologist, community psychiatric nurse etc), on the case load of a children's community nursing team, was seen by a health visitor within the last 6 months, was under a community midwife (ie teenage pregnancy), or was on the caseload of drug and alcohol services. It may also apply if a parent or carer was in receipt of health services.

**5. Armed Services**

***Direct involvement***

This applies if the young person was in any of the services, but not on leave or absent without leave.

**Score**

***Indirect involvement***

This applies if the young person was in any of the services, and on leave or absent without leave. It also applies if the child had parents in the services and that service provided the family with its living accommodation.

**6. Police or criminal justice system**

***Direct involvement***

This applies if the child or young person was in custody, on remand, in gaol, or under the direct physical care of police personnel, a probation worker, a prison warder, court official, etc.

**Score**

***Indirect involvement***

This applies, for example, if the young person was on parole, subject to police bail, subject to an antisocial behaviour order or other court order, or was on probation but not in the company of a probation officer.

**7. Voluntary sector**

***Direct involvement***

This applies if the child was being directly supervised by a worker from a voluntary agency such as NSPCC or Barnadoes, including being in a nursery or playgroup provided by a voluntary agency.

**Score**

***Indirect involvement***

This applies if the child was on the caseload of a voluntary agency such as NSPCC or Barnadoes.



**8. Other**

***Direct involvement***

Any other agency not previously listed, with direct or vicarious responsibility for the child or young person at the time of onset of injury or serious illness leading to death. Examples could be commercial organisations, clubs or associations offering instruction in sports or leisure activities (football, golf, riding); the organisers of a sports event where the child was either spectator or participant; businesses; providers of public transport; hotels; commercial nurseries or crèches.

**Score**

**Specify the agency:** \_\_\_\_\_

***Indirect involvement***

This might apply to the child of an asylum seeking family in a government detention facility, or a child or family under the jurisdiction of a non-UK organisation. It could include agencies with responsibility for public safety such as the Highways Agency, Health Protection Agency, local government, Network Rail etc.

**Specify the agency:** \_\_\_\_\_

**9. No agency involvement, direct or indirect**

***Situation***

This will apply to children who have run away from home; are abandoned; in prostitution, etc. It also applies to any young people who were married or cohabiting independently of their parents. Specify the situation and score its relevance.

**Score**

---

**SECTION E**  
**Medical care**

---

There may be avoidable factors relating to the medical care of the child that increased the chance of death. This will usually relate to the medical care of the child for a life-threatening illness or following injury.

Score the assessed contribution as follows:

- 0 Known to be present, but not relevant to the death
- 1 Probably a minor or background factor among the events leading up to the death
- 2 Probably a significant factor among the events leading up to the death
- 3 Probably a major factor, but one of several others impacting on the death
- 4 Directly and overwhelmingly important factor in the death
  
- 6 Known to be present, but contribution cannot be estimated
- 7 Documents available to panel confirm that factor was not present
- 8 Documents available to panel do not state whether or not the factor was present
- 9 Not applicable to this child

**Either:**

- This section is not applicable because there was no medical care involved prior to the child's death. If so, go to section F.**

**Or: This section is applicable as follows.**

- 1. Consider whether there was any evidence of failure to recognise the problem or its severity outside hospital, including at home.**

<b>Potential contribution</b>	<b>Score</b>
Medical staff	<input type="checkbox"/>
Nursing staff, including health visitors	<input type="checkbox"/>
Carers	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>

**SECTION E continued**

**2. Consider whether there was any evidence of failure to act appropriately with respect to the child outside hospital, including at home (eg instructions from ambulance service), or by paramedics, or by ‘good samaritan’ actions of a health professional.**

<b>Potential contribution</b>	<b>Score</b>
Medical staff	<input type="checkbox"/>
Nursing staff, including health visitors	<input type="checkbox"/>
Carers	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>

**3. Consider whether there was any evidence of failure to communicate appropriately with respect to the child outside hospital, including instructions from ambulance control or NHS direct, or between professionals, or between services (eg ambulance and hospital).**

<b>Potential contribution</b>	<b>Score</b>
Medical staff	<input type="checkbox"/>
Nursing staff, including health visitors	<input type="checkbox"/>
Carers	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>

**4. Consider whether there was any evidence of failure to recognise the problem or its severity at hospital.**

<b>Potential contribution</b>	<b>Score</b>
Medical staff	<input type="checkbox"/>
Nursing staff, including health visitors	<input type="checkbox"/>
Carers	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>



**SECTION E continued**

**5. Consider whether there was any evidence of failure of management of the child – for instance, evidence of unnecessary delay in initiating treatment or transferring the child to appropriate facilities such as PICU or surgery.**

<b>Potential contribution</b>	<b>Score</b>
Medical staff	<input type="checkbox"/>
Nursing staff, including health visitors	<input type="checkbox"/>
Carers	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>

**6. Consider whether there was any evidence of failure to communicate between professionals, or between services (eg ambulance and hospital), or with parents.**

<b>Potential contribution</b>	<b>Score</b>
Medical staff	<input type="checkbox"/>
Nursing staff, including health visitors	<input type="checkbox"/>
Carers	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>

**7. Consider whether there was any evidence of failure to supervise junior professionals at any stage in the child’s progress.**

<b>Potential contribution</b>	<b>Score</b>
Medical staff	<input type="checkbox"/>
Nursing staff, including health visitors	<input type="checkbox"/>
Carers	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>



**SECTION E continued**

**8. Consider whether there was any evidence of an adverse event in hospital that affected care (for example: drug error, unexpected collapse, equipment failure, monitoring failure, iatrogenic injury etc), or whether there was any issue of resources (appropriate grade of medical or nursing staff, equipment, beds etc).**

<b>Potential contribution</b>	<b>Score</b>
Medical staff	<input type="checkbox"/>
Nursing staff, including health visitors	<input type="checkbox"/>
Carers	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>

**9. Once assessed at a hospital, the child may have been transported to another facility for intensive care, neurosurgery or other treatment. Consider whether any aspect of this may have contributed to the death.**

<b>Potential contribution</b>	<b>Score</b>
Medical staff	<input type="checkbox"/>
Nursing staff, including health visitors	<input type="checkbox"/>
Carers	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>
Other professional (specify): _____	<input type="checkbox"/>




---

**SECTION F**  
**Documentation**

---

In relation to the documents available to the panel, were there any significant omissions of detail or of whole records that members would have valued in coming to their conclusions?

Score the assessed contribution to the panel's judgments as follows:

- 0 No significant omissions
- 1 Probably minor or background information missing
- 2 Probably significant information missing
- 3 Probably major information missing, but other important information present
- 4 Most of the extremely important information was missing
  
- 7 Other relevant documents are known to exist, but contribution cannot be estimated
- 8 Other relevant documents are presumed to exist, but the panel cannot be sure of this
- 9 Not applicable to this child

**Nature of missing information or record**

**Score**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_



---

**SECTION G**  
**Local case review of this death**

---

**If the panel had access to a local case review, are there reasons for the panel to come to different conclusions to that review? Briefly state the relevant issues/recommendations:**

---

**SECTION H**  
**Good practice**

---

The panel is asked to highlight areas of good practice

**Aspects of good practice**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_




---

**SECTION I**  
**Autopsy**

---

If there is a post-mortem report, the panel should consider the extent to which it contributed to the overall understanding of the case in relation to producing new information about the death.

- 0 No new factor relevant to the death
- 1 Probably a minor or background additional factor
- 2 Probably a significant additional factor
- 3 Probably a major additional factor, but one of several others impacting on the death
- 4 New, directly and extremely important additional factor in the death
  
- 6 Examination believed to have been done, but no report available to the panel
- 7 No direct evidence in the documents as to whether examination was done
- 8 Examination was not done (for example, no histology)
- 9 Not applicable to this child

<b>Aspect of Autopsy report</b>	<b>Score</b>
Macroscopic external examination	<input type="checkbox"/>
Macroscopic internal examination	<input type="checkbox"/>
Histology	<input type="checkbox"/>
Other test (specify) _____	<input type="checkbox"/>
Other test (specify) _____	<input type="checkbox"/>

---

**SECTION J**  
**Death Certificate**

---

If the panel does not have access to information on the death certificate, please score this section 9.  
If the panel has access to the information on the death certificate, please copy it below:

**la** \_\_\_\_\_

**lb** \_\_\_\_\_

**lc** \_\_\_\_\_

**ll** \_\_\_\_\_

Does the panel consider that their deliberations identified any additional relevant factors that would amend the death certificate?

Please use the scoring below to answer:

- 0 The panel did not identify any **new** factors relevant to the death that would amend the death certificate in any way.
- 1 The panel did not identify any **new** factors relevant to the death but feel that the ordering of causation is incorrect.

If the panel did identify additional factors, please select from 2-5:

- 2 Probably a minor or background factor among the events leading up to the death
- 3 Probably a significant factor among the events leading up to the death
- 4 Probably a major factor, but one of several others impacting on the death
- 5 Directly and overwhelmingly important factor in the death
  
- 7 The panel believes there may be other relevant factors, but not available to them
- 8 The nature of the case prevents such a judgement being made
- 9 Not applicable (eg child died abroad)

**Score:**



---

## SUMMARY PAGE

---

Please use the box below to summarise the case in two or three sentences. Highlight any concerns about communication between agencies or persons and any opinion as to whether the death resulted from a series of low level contributory factors by one or more persons or agencies, or whether there was an obvious single factor. Bring out any other factors not adequately highlighted in previous sections.

### RECOMMENDATIONS AND LEARNING POINTS

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

**The panel should now categorise the death, based on ‘avoidability’.**

This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be chosen.

**1) Avoidable**

- a) Where there were identifiable failures in the child’s direct care by any agency, including parents, with direct responsibility for the child
- b) Where there were latent, organisational or other indirect failure(s) within one or more agency, including parents, with direct or indirect responsibility for the child
- c) Where there was a failure of agencies with responsibility for public safety (poor design, dilapidation of barriers, or inadequate maintenance, eg rail maintenance leading to Hatfield rail disaster)

**2) Potentially avoidable**

- a) At a higher level than the agencies with direct or indirect responsibility for the child (eg political violence, war, terrorism, crime, and if the child is the victim of homicide)
- b) Where no agency, including parents, was involved directly or indirectly with the child
- c) Where intrinsic factors (eg an acquired disease with a known high mortality such as meningococcaemia) were the principal factors leading to the death
- d) Where there were potentially modifiable factors extrinsic to the child
- e) Where the causal pathway leading to the death could reasonably be traced back to antepartum or intrapartum obstetric events

**3) Unavoidable**

- a) Death caused by unmodifiable factors extrinsic to the child (eg lightning strike)
- b) Death due to undiagnosed, asymptomatic conditions presenting with a lethal event (eg hypertrophic obstructive cardiomyopathy)
- c) Planned palliation for unpreventable, incurable disease or anomaly (eg Leigh’s disease)