



HEAD INJURY IN CHILDREN

NOTIFICATION FORM (A)

Please complete this form for a child or young person up to 15 years old (*14 yrs + 365 days*) who as a result of a head injury* or a head injury as part of a pattern of injuries meets ONE of the following criteria between 1st SEPTEMBER 2009 and 28th FEBRUARY 2010 inclusive:

Please tick type of case: *(Select one option only)*

- Seen in your Emergency Department and admitted* to your hospital for secondary or tertiary care **OR**
- Seen in your Emergency Department but transferred for admission* to secondary or tertiary care at another hospital (within or out of your trust) **OR**
- Seen in your Emergency Department but died before admission* or transfer* to secondary care **OR**
- Died at the scene or died between the scene and attendance at the first hospital.

Instructions for completing and returning the notification form

- Certain sections may not be applicable to all children. Please read the guidance manual before completing.
- Please complete the form using the information available in the child's notes. Complete all dates in the format DD/MM/YY and times using the 24hr clock e.g. 18:50.
- Please keep a copy of this form for your records. Return hardcopies of completed forms to your local CMACE regional office. See back of form for local contact details.**
- If you have any queries about completing or returning this form please contact your CMACE regional office.

Date form completed:

 / /

Date form returned:

 / /

DETAILS OF PERSON COMPLETING FORM

Name:	Trust:
Job title/Role:	Telephone:
Unit:	Email:
Hospital:	

* **Head injury:** Examples of head injuries to include or exclude can be found on the back of this form.

* **Admission:** Hospital admission is defined as occurring when the patient is in receipt of treatment or observation in an inpatient area. This includes short term assessment units associated with wards or emergency departments, short stay units, general or specialist wards, PICUs, Neurosurgical unit, or other inpatient unit. This may only be for a matter of hours beyond the first four hours from arrival at hospital.

* **Transfer:** Refers to the transport of a patient by ambulance (land or air) from one hospital to another hospital facility. Also referred to as an 'inter-hospital transfer' between two hospitals either within or out of the same trust.

Is this the first hospital the child attended following the incident?

Yes No
→ If no, hospital child transferred from _____

SECTION 1: DETAILS OF CHILD

(Affix patient label if preferred)

1.1 Hospital Number

1.2 NHS Number/Healthcare Number / /

1.3 Surname/family name _____

1.4 First name _____

1.5 Sex Male Female Not known

1.6 Date of birth and/or estimated age
If no full date of birth is known enter month and year. If no full or short DOB, enter their estimated age.
 / / Not known
 years months

1.7 Address of patient's normal residence _____
Postcode of patient's normal residence / Not known

1.8 Ethnic group Not known

White	Mixed:	Asian or Asian British	Black or Black British:	Other ethnic groups:
<input type="checkbox"/> English	<input type="checkbox"/> White & Black Caribbean	<input type="checkbox"/> Indian	<input type="checkbox"/> Caribbean	<input type="checkbox"/> Arab
<input type="checkbox"/> Other British	<input type="checkbox"/> White & Black African	<input type="checkbox"/> Pakistani	<input type="checkbox"/> African	<input type="checkbox"/> Gypsy/ Romany/ Irish Traveller
<input type="checkbox"/> Irish	<input type="checkbox"/> White & Asian	<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Other Black background	<input type="checkbox"/> Other ethnic group
<input type="checkbox"/> Any other white background	<input type="checkbox"/> Any other Mixed background	<input type="checkbox"/> Chinese		
		<input type="checkbox"/> Any other Asian background		

If other, please specify _____

1.9 Child known to Social Services Yes No Not known
If answering this question is not indicated as part of the admission process and you are unaware of whether the child is or is not known to Social Services, tick 'Not known'. i.e. you are not required to call Social Services to answer this question.

1.10 Child subject of existing child protection plan Yes No Not known

SECTION 2: DETAILS OF INCIDENT

2.1 Date of incident / / Not recorded

2.2 Time of incident : (24 hr clock) Not recorded

2.3 Postcode of incident location / Not known
If postcode is not known indicate area/first line of address _____ Not known

2.4 Place of incident
 Home/private address Road/ Street/Motorway School/ Nursery Other, specify _____ Not known

2.5 Cause of injury
 Struck by car (i.e. child was pedestrian) Sport, please specify _____
 Motor vehicle accident (not pedestrian) Other recreational (e.g. skateboard) specify _____
 Cycling Assault
 Fall from > 1m or > 5 stairs Other, please specify _____
 Fall < 1m or < 5 stairs Not known
 Fall, height unknown

2.6 Additional incident details, if known (e.g. Fall from trampoline, speed, not in age appropriate car seat, etc)
Please use the additional space provided on page 7 if there is not enough room to complete your answer

2.7 Suspicion of Non Accidental Injury (NAI) Yes No Not known

2.8 Seatbelt worn Yes No Not known N/A

2.9 Helmet worn Yes No Not known N/A

SECTION 4: EMERGENCY DEPARTMENT

- 4.1 Name of Hospital _____
- 4.2 Date of arrival at the Emergency Department DD/MM/YY Not recorded
- 4.3 Time of arrival at the Emergency Department HH:MM (24 hr clock) Not recorded

Previous attendance/s

- 4.4 Was this current visit a re-attendance in relation to a previous injury? (that occurred within 72 hours of this attendance) Yes → Go to 4.4.1 No → Go to 4.5 Not known → Go to 4.5
- 4.4.1 Name of hospital first attended _____ Not known
- 4.4.2 Date attended that hospital DD/MM/YY Not recorded
- 4.4.3 Time of review at previous attendance HH:MM (24 hr clock) Not recorded
- 4.4.4 Grade of clinician who discharged child (see codes on page 7) Not known
- 4.4.5 Head CT scan at previous attendance Yes No Not known

This attendance

- 4.5 Details of first clinical assessment for this attendance (please refer to codes on page 7)
This refers to the first clinical assessment (i.e. not included assessment by the triage nurse)
- 4.5.1 Grade of clinician (see codes on page 7) Not recorded
- 4.5.2 Speciality of clinician (see codes on page 7) Not recorded
- 4.5.3 Time of first clinical assessment (i.e. not assessment by the triage nurse) HH:MM (24 hr clock) Not recorded
- 4.6 Following first clinical assessment (i.e. not assessment by triage nurse) was the child referred for consideration by:
- 4.6.1 A more senior member of medical team Yes No Not known
- 4.6.2 Another speciality Yes No Not known
- 4.7 Child's neurological status in the Emergency Department
Document the worst score before intubation/intervention in the Emergency Department. If no intubation/intervention occurred in the Emergency Department, document the worst score.
- 4.7.1 Glasgow Coma Scale Score Not recorded
- | | |
|-------------------|--|
| Eye opening | |
| Verbal response | |
| Motor response | |
| TOTAL (out of 15) | |
- Time GCS recorded: HH:MM (24 hr clock) Not recorded
- 4.7.2 AVPU Score Not recorded
- | | |
|------------------|--|
| Alert | |
| Respond to Voice | |
| Respond to Pain | |
| Unresponsive | |
- Time AVPU recorded: HH:MM (24 hr clock) Not recorded
- 4.8 Child intubated in the Emergency Department Yes No Not known

IMAGING

(At any time following attendance)

- 4.8 Head CT scan performed Yes → Go to 4.8.1 No → Go to 4.8.4 Not known → Go to 4.9
- 4.8.1 Date first head CT scan performed DD/MM/YY Not recorded
- 4.8.2 Time first head CT scan performed HH:MM (24 hr clock) Not recorded
- 4.8.3 Was the first head CT scan reported as normal on provisional report? Yes → Go to 4.9 No → Specify abnormality: _____ Not known → Go to 4.9
- 4.8.4 If no head CT performed, please indicate reason/reasons why: (tick all that apply)
- CT scan already done at first hospital Child not stable Other, please specify _____
- Not considered to be clinically indicated No CT available Not known

IMAGING continued*(At any time following attendance)*

- 4.9 Complete cervical spine CT performed** Yes → *Go to 4.9.1.* No → *Go to 4.9.2* Not known → *Go to 4.10*
- 4.9.1 Was the first spine CT scan reported as normal on provisional report?** Yes → *Go to 4.10* No → *Specify abnormality:* Not known → *Go to 4.10*

4.9.2 If no spine CT scan performed please indicate reason/reasons why: *(tick all that apply)*

- CT scan already done at first hospital Child not stable Other, *please specify* _____
- Not considered to be clinically indicated No CT available Not known

- 4.10 Was the child 'admitted' to your hospital?** Yes → *Go to 5.1* No → *Go to 4.10.1*
(see cover for definition of admission)

4.10.1 If no, where did child go following discharge from the Emergency Department

- Transferred to another hospital → *Go to 6.2*
- Deceased → *Go to 6.4*
- Other, *please specify* _____ → *Go to 6.1*

SECTION 5: ADMISSION

5.1 Area child first admitted to:

- General children's ward General/Adult ICU Theatre
- Paediatric Intensive Care Unit (PICU) Adult Neurosurgical unit Short stay Unit
- Paediatric Neurosurgical unit Adult High Dependency Unit (HDU) Observation unit
- Paediatric High Dependency Unit (PHDU) Other, *specify* _____ Not known
- Specialist children's ward, *specify* _____

5.2 Date admitted to area / / *Not recorded*

5.3 Time admitted to area : *(24 hr clock)* *Not recorded*

5.4 Designated lead team for this admission *(If joint care tick all that apply)*

- General Paediatrics General/Adult Emergency Medicine Not known
- Paediatric Emergency Medicine General/Adult Intensive Care Other, *specify* _____
- Paediatric Intensive Care Adult Neurosurgery
- Paediatric Neurosurgery General/Adult Surgery
- Paediatric Surgery Orthopaedic Surgery

5.5 Indication for admission *(Please tick all that apply)*

- Severity of the head injury Recovery from GA or sedation used for CT scan
- Severity of other injuries Child fulfils criteria for CT scanning but this cannot be done within the appropriate period
- Severity of mechanism of injury Not sufficiently cooperative to allow scanning
- Continuing worrying signs in relation to head injury Admitted for GA to have a CT scan
- Abnormality identified on CT scan Shock
- Base of skull fracture Suspected Non Accidental Injury (NAI)
- Meningism Other, *please specify (e.g. not related to head injury, gastroenteritis)*
- CSF leak
- Drug or Alcohol intoxication

5.6 Consultant paediatrician involved in care of child Yes No Not known
(i.e. Discussed with at time of care delivered)

5.7 Neurosurgeon involved in care of child Yes No Not known
(This includes liaison over telephone, or other means)

5.8 Specialist in Child Protection with level 3 training or above involved Yes No Not known
(i.e. Discussed with at time of care delivered)

5.9 Child Protection referral made to external body Yes No Not known
(e.g. Social Services or Police)

5.10 Skeletal survey undertaken Yes No Not known
(i.e. as part of a child protection assessment)

5.11 Review by ophthalmology undertaken Yes No Not known
(i.e. as part of a child protection assessment)

SECTION 5: ADMISSION *continued*

5.12 IN ADDITION to the first area of admission, was the child *at any time during the first 72 hours post injury* admitted to any of the following areas?

Area	Yes	No	Date admitted	Time admitted (24 hr clock)	Date discharged	Time discharged (24 hr clock)
a. PICU	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
b. PHDU	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
c. General ICU	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
d. General HDU	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
e. Neurosurgical unit	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
f. Ward	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
g. Theatre	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM
h. Other, <i>specify</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	DD/MM/YY	HH:MM	DD/MM/YY	HH:MM

SECTION 6: CHILD'S OUTCOME - Complete at whichever occurs first: at transfer, at death in hospital, or at the end of the first 72 hours post injury.

6.1 Please indicate the status or location of the child at whichever occurs first

(i.e. at transfer, at death in hospital, or at the end of the first 72 hours post injury)

- | | | |
|---|---|---|
| <input type="checkbox"/> Transferred → <i>Go to 6.2</i> | <input type="checkbox"/> Paediatric Intensive Care Unit (PICU) | <input type="checkbox"/> Adult/General HDU |
| <input type="checkbox"/> Discharged → <i>Go to 6.3</i> | <input type="checkbox"/> Paediatric High Dependency Unit (PHDU) | <input type="checkbox"/> Not known |
| <input type="checkbox"/> Deceased → <i>Go to 6.4</i> | <input type="checkbox"/> Paediatric Neurosurgical unit | <input type="checkbox"/> Other, <i>specify</i>
_____ |
| <input type="checkbox"/> General children's ward | <input type="checkbox"/> General/Adult ICU | |
| <input type="checkbox"/> Specialist children's ward, <i>specify</i> _____ | <input type="checkbox"/> Adult Neurosurgical unit | |

6.2 Transferred

- 6.2.1 Was this a transfer or retrieval? Transfer Retrieval Not known
- 6.2.2 Name of hospital and trust child transferred to (Hospital) _____
(Trust) _____
- 6.2.3 Date and time first referral made for transfer DD/MM/YY HH:MM (24 hr clock) Not recorded
- 6.2.4 First referral request for transfer accepted Yes No
- 6.2.5 Date and time departure for transfer DD/MM/YY HH:MM (24 hr clock) Not recorded
- 6.2.6 Reason for transfer (please tick all that apply)
- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> No paediatric facilities | <input type="checkbox"/> Access to paediatric neuroscience facilities | <input type="checkbox"/> Not recorded |
| <input type="checkbox"/> No ICU facilities in hospital | <input type="checkbox"/> Paediatric surgery | <input type="checkbox"/> Not known |
| <input type="checkbox"/> No PICU bed available in hospital | <input type="checkbox"/> Receiving hospital close to child's home | |
| <input type="checkbox"/> No general ICU bed available in hospital | <input type="checkbox"/> Other, <i>please specify</i> _____ | |
- 6.2.7 Means of transfer
- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Specialist PICU transport team | <input type="checkbox"/> Private/public transport | <input type="checkbox"/> Not recorded |
| <input type="checkbox"/> Local team | <input type="checkbox"/> Other land, <i>please specify</i> _____ | <input type="checkbox"/> Not known |
| <input type="checkbox"/> Paramedic Ambulance | <input type="checkbox"/> Helicopter (Paramedic/medic) | |
| <input type="checkbox"/> Ambulance (Non paramedic) | <input type="checkbox"/> Other airborne, <i>please specify</i> _____ | |
- 6.2.8 Additional transfer information (e.g. reason for delay)

SECTION 6: CHILD'S OUTCOME *continued*

6.3 Discharged

- 6.3.1 Place child discharged to Home Rehab centre
 Other, *specify* _____ Not known
- 6.3.2 Date of discharge DD/MM/YY Not recorded
- 6.3.3 Time of discharge HH:MM (24 hr clock) Not recorded
- 6.3.4 Diagnosis on discharge _____

6.4 Death *(if a diagnosis of brain stem death is made then the date and time of this diagnosis equals the date and time of death)*

- 6.4.1 Date of death DD/MM/YY Not recorded
- 6.4.2 Time of death HH:MM (24 hr clock) Not recorded
- 6.4.3 Place of death
- | | | |
|---|---|---|
| <input type="checkbox"/> General children's ward | <input type="checkbox"/> General/Adult ICU | <input type="checkbox"/> Theatre |
| <input type="checkbox"/> Paediatric Intensive Care Unit (PICU) | <input type="checkbox"/> Adult Neurosurgical unit | <input type="checkbox"/> Short stay Unit |
| <input type="checkbox"/> Paediatric Neurosurgical unit | <input type="checkbox"/> Adult High Dependency Unit (HDU) | <input type="checkbox"/> Observation unit |
| <input type="checkbox"/> Paediatric High Dependency Unit (PHDU) | <input type="checkbox"/> Emergency Department | <input type="checkbox"/> Home |
| <input type="checkbox"/> Specialist children's ward, <i>specify</i> _____ | <input type="checkbox"/> Other, <i>specify</i> _____ | <input type="checkbox"/> Not known |
- 6.4.4 Death certificate issued Yes No Not known
- 6.4.5 Coroner's referral made Yes No Not known
- 6.4.6 Cause of death *(as stated on death certificate. If no certificate issued state cause of death as in notes)*

For children who died <28 days old

- 1 _____
- 2a. _____
- 2b. _____
- 2c. _____
- 2d. _____

For deaths of a child (> 28 days old)

- 1a. _____
- 1b. _____
- 1c. _____
2. _____

Additional space for further information *(please indicate question number you are referring to)*

PLEASE PHOTOCOPY THIS FORM AND KEEP A COPY FOR YOUR RECORDS BEFORE RETURNING TO YOUR CMACE REGIONAL OFFICE

Speciality & Clinician Codes

CODE	SPECIALITY	CODE	SPECIALITY	CODE	CLINICIAN
100	General Surgery	302	Endocrinology	CONS	Consultant
110	Trauma & Orthopaedics	303	Clinical Haematology	SG	Staff Grade
120	Ear Nose Throat (ENT)	400	Neurology	CF	Clinical Fellow
145	Oral & Maxillo Facial Surgery	401	Clinical Neuro-Physiology	AS	Associate Specialist
150	Neurosurgery	420	Paediatrics	ST + 1-8	Single Training e.g. ST4
170	Cardiothoracic Surgery	421	Paediatric Neurology	SpR + year	Specialist Registrar e.g. SpR2
171	Paediatric Surgery	450	Dental Medicine Specialities	FY + year	Foundation year e.g. if year 1, enter FY1
180	Emergency Medicine	460	Medical Ophthalmology	ENP	Emergency Nurse Practitioner
190	Anaesthetics	600	General Medical Practice	APNP	Advanced Paediatric Nurse Practitioner
192	Critical Care Medicine	601	General Dental Practice	ATNC	Nurse - Advance Trauma Cert
193	Paediatric Intensive Care	810	Radiology	RSCN	Nurse - RSCN
300	General Medicine	823	Haematology	NURS	Nurse - General
301	Gastroenterology	000	Other (Surgical or Medical)	GP	General Practitioner

Inclusion & exclusion criteria

Please include:

- Children up to 15 years old (14 years and 364 days) who between 00:00 on the 1st September 09 and 23:59 on the 28th February 2010 have a brain or skull injury (trauma to the head) as a result of blunt or penetrating trauma or acceleration or deceleration force (e.g. road traffic accident, fall, shaking) **OR** who have experienced a head injury as part of a pattern of injuries or multi trauma **AND** fulfill the following length of stay criteria:

- | | | |
|---|-----------|--|
| ⇒ Admitted to an area of inpatient care (regardless of length of stay) | OR | |
| ⇒ Died in the hospital, including the Emergency Department | OR | Definition of 'admission' can be found on the front of this form |
| ⇒ Transferred to other hospital for specialist care or for an ICU/HDU bed | OR | |
| ⇒ Died at the scene or en route to the receiving hospital | OR | |
| ⇒ Transferred in to your hospital (regardless of length of stay) | | |

Please exclude:

- Children who have experienced primarily superficial or facial injuries which are *unlikely to be associated with a brain injury* (e.g. isolated or trivial facial (nose, ear, lip etc), scalp or auricular injuries)
- Children who do not meet the above inclusion criteria (i.e. children who do not die that are not admitted; children who have reached their 15th birthday at the time of injury).

Examples of types of head injuries to be INCLUDED	Examples of types of head injuries to be EXCLUDED
S02 Fracture of skull and facial bones, e.g.	S00 Superficial Injuries, e.g.
Fracture of vault of skull	Superficial injury of scalp
Fracture of base of skull	Contusion of eyelid and periocular area
Multiple fractures involving skull and facial bones	Other superficial injuries of eyelid and periocular area
Fractures of other skull and facial bones	Superficial injury of nose, ear, lip, or oral cavity
S04 Injury of cranial nerves, e.g.	S01 Open wound of head, e.g.
Injury of optic nerve and pathways	Scalp, eyelid and periocular area, nose, ear, cheek & temporomandibular area, lip & oral cavity.
Injury of oculomotor nerve	
S06 Intracranial injury, e.g.	S02 Fracture of skull and facial bones, e.g.
Concussion	Fracture of tooth, mandible, nasal bones, orbital floor, malar & maxillary bones.
Traumatic cerebral oedema	
Diffuse brain injury	S03 Dislocation, sprain & strain of joints & ligaments of head,
Focal brain injury	Dislocation of jaw, septal cartilage of nose, septal cartilage of nose, or tooth. Sprain and strain of jaw.
EDH (Extra Dural Haematoma)	
Traumatic subdural/subarachnoid haemorrhage	S04 Injury of cranial nerves, e.g.
	Injury of trochlear nerve, trigeminal nerve, abducent nerve, facial nerve
Intracranial injury with prolonged coma	
Other intracranial injuries	S05 Injury of eye and orbit, e.g.
Intracranial injuries - unspecified	Injury of conjunctiva and corneal abrasion
S07 Crushing injury of head, e.g.	Contusion of eyeball and orbital tissues
Crushing injury of the face	Ocular laceration and rupture with prolapse
Crushing injury of the skull	Penetrating wound of orbit, or eyeball
	Avulsion of eye
S08 Traumatic amputation of part of head, e.g.	S08 Traumatic amputation of part of head, e.g.
Traumatic amputations	Avulsion of scalp
Multiple injuries of head	Traumatic amputation of ear

If you have any queries regarding the inclusion/exclusion criteria, please contact your CMACE regional office.

CMACE East of England Office

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