For office use only: ☐☐ HI ☐☐☐☐

Centre for Maternal and Child Enquiries

Improving the health of mothers, babies and children

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

1. Certain sections may not be applicable to all children. Please read the guidance manual before completing.
2. 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*.
3. **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.**
4. If you have any queries about completing or returning this form please contact your CMACE regional office.

Date form completed: D D / M M / Y Y **Date form returned:** D D / M M / Y Y

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.

D D / M M / Y Y ☐ 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:***
☐ English	☐ White & Black Caribbean	☐ Indian	☐ Caribbean	☐ Arab
☐ Other British	☐ White & Black African	☐ Pakistani	☐ African	☐ Gypsy/ Romany/ Irish Traveller
☐ Irish	☐ White & Asian	☐ Bangladeshi	☐ Other Black background	☐ Other ethnic group
☐ Any other white background	☐ Any other Mixed background	☐ Chinese		
		☐ 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 D D / M M / Y Y ☐ *Not recorded*

2.2 Time of incident H H : M M *(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)*
☐ Motor vehicle accident (not pedestrian)
☐ Cycling
☐ Fall from > 1m or > 5 stairs
☐ Fall < 1m or < 5 stairs
☐ Fall, height unknown
☐ Sport, *please specify* _____
☐ Other recreational *(e.g. skateboard) specify* _____
☐ Assault
☐ Other, *please specify* _____
☐ Not known

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 2: DETAILS OF INCIDENT *continued*

2.10 **Did the child sustain any other injury to other area(s) of their body?** *(e.g. bruises, fractures)* ☐ Yes *→ Go to 2.11* ☐ No *→ Go to 2.12* ☐ Not known *→ Go to 2.12*

2.11 **If yes, please indicate whether the child sustained any other injuries to the following areas**
(If an injury is 'Not recorded' then tick 'Minor/None')

	Major - requiring hospital admission itself	Minor/None	Not Known
a. Head	☐	☐	☐
b. Face	☐	☐	☐
c. Neck	☐	☐	☐
d. Chest	☐	☐	☐
e. Abdomen (including pelvic contents)	☐	☐	☐
f. Spine	☐	☐	☐
g. Limbs (excluding pelvic girdle)	☐	☐	☐
h. Bone pelvis	☐	☐	☐
i. Body surface (penetrating)	☐	☐	☐
j. Body surface (blunt)	☐	☐	☐
k. Burns	☐	☐	☐
l. Other, *specify* _____	☐	☐	☐

Please use the additional space on page 7 to provide additional details on these other injuries, if information available

2.12 **Child experienced a period of loss of consciousness** *(at any time)* ☐ Yes ☐ No ☐ Not known

2.13 **Route of referral to this Emergency Department**

☐ 999 Ambulance Service
☐ Minor Injury Unit, *(specify)* _____
☐ Other hospital, *(specify)* _____
☐ Self/Parental referral
☐ Telephone advice – NHS Direct
☐ GP assessment unit
☐ GP surgery
☐ Not known
☐ Other *(specify)* _____

2.14 **Mode of arrival to the first hospital**

☐ Road ambulance *→ Go to Section 3*
☐ Air ambulance *→ Go to Section 3*
☐ Private/public transport *→ Go to Section 4*
☐ Other, *specify* _____ *→ Go to Section 4*

SECTION 3: PRE HOSPITAL – AT SCENE/EN ROUTE

Please complete the following details as fully as possible from the child's notes. This will help us to be able to obtain records from the ambulance services. Referring to the guidance manual will help you.

3.1 **Name of Ambulance Service involved** _____ ☐ *Not recorded*

3.2 **Ambulance notes in the child's hospital records** ☐ Yes ☐ No

3.3 **Patient Report Form number** ☐☐☐☐☐☐☐☐☐☐☐☐ ☐ Not known

3.4 **Incident number/CAD number (or equivalent)** ☐☐☐☐☐☐☐☐☐☐☐☐ ☐ Not known

3.5 **On arrival of emergency services at the scene child was found to be:**
☐ Alive *→ Continue completing this section*
☐ Dead *→ Go to Section 6*

3.6 **Child's neurological status at scene**
Document the worst score before intubation/intervention. If no intubation/intervention occurred, document the worst score.

3.6.1 **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*

3.6.2 **AVPU Score** ☐ *Not recorded*

***A**lert*	
*Respond to **V**oice*	
*Respond to **P**ain*	
***U**nresponsive*	

Time AVPU recorded:
HH:MM *(24 hr clock)* ☐ *Not recorded*

3.7 **Child intubated at scene/en-route** ☐ Yes ☐ No ☐ Not known

3.8 **Other mechanical airway/breathing assistance employed at scene/en-route** *(e.g. Bagging/BVM)* ☐ Yes ☐ No ☐ Not known ☐ *Not recorded*

SECTION 4: EMERGENCY DEPARTMENT

4.1 Name of Hospital _____

4.2 Date of arrival at the Emergency Department D D / M M / Y Y ☐ *Not recorded*

4.3 Time of arrival at the Emergency Department H H : M M *(24 hr clock)* ☐ *Not recorded*

Previous attendance/s

4.4 Was this current visit a re-attendance in relation to a previous injury? ☐ Yes *→ Go to 4.4.1* ☐ No *→ Go to 4.5* ☐ Not known *→ Go to 4.5*
(that occurred within 72 hours of this attendance)

4.4.1 Name of hospital first attended _____ ☐ Not known

4.4.2 Date attended that hospital D D / M M / Y Y ☐ *Not recorded*

4.4.3 Time of review at previous attendance H H : M M *(24 hr clock)* ☐ *Not recorded*

4.4.4 Grade of clinician who discharged child ☐☐☐☐ ☐ Not known
(see codes on page 7)

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 H H : M M *(24 hr clock)* ☐ *Not recorded*
(i.e. not assessment by the triage nurse)

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:
H H : M M *(24 hr clock)* ☐ *Not recorded*

4.7.2 AVPU Score ☐ *Not recorded*

***A**lert*	
*Respond to **V**oice*	
*Respond to **P**ain*	
***U**nresponsive*	

Time AVPU recorded:
H H : M M *(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 D D / M M / Y Y ☐ *Not recorded*

4.8.2 Time first head CT scan performed H H : M M *(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
☐ Not considered to be clinically indicated
☐ Child not stable
☐ No CT available
☐ Other, *please specify* _____
☐ 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
☐ Not considered to be clinically indicated
☐ Child not stable
☐ No CT available
☐ Other, *please specify* _____
☐ Not known

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

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

5.2 Date admitted to area D D / M M / Y Y ☐ *Not recorded*

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

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

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

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

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

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

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

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

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

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

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

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	☐	☐	D D/M M/Y Y	H H:M M	D D/M M/Y Y	H H:M M
b. PHDU	☐	☐	D D/M M/Y Y	H H:M M	D D/M M/Y Y	H H:M M
c. General ICU	☐	☐	D D/M M/Y Y	H H:M M	D D/M M/Y Y	H H:M M
d. General HDU	☐	☐	D D/M M/Y Y	H H:M M	D D/M M/Y Y	H H:M M
e. Neurosurgical unit	☐	☐	D D/M M/Y Y	H H:M M	D D/M M/Y Y	H H:M M
f. Ward	☐	☐	D D/M M/Y Y	H H:M M	D D/M M/Y Y	H H:M M
g. Theatre	☐	☐	D D/M M/Y Y	H H:M M	D D/M M/Y Y	H H:M M
h. Other, *specify* _____	☐	☐	D D/M M/Y Y	H H:M M	D D/M M/Y Y	H H:M M

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)

- ☐ Transferred → *Go to 6.2*
- ☐ Discharged → *Go to 6.3*
- ☐ Deceased → *Go to 6.4*
- ☐ General children's ward
- ☐ Specialist children's ward, *specify* _____
- ☐ Paediatric Intensive Care Unit (PICU)
- ☐ Paediatric High Dependency Unit (PHDU)
- ☐ Paediatric Neurosurgical unit
- ☐ General/Adult ICU
- ☐ Adult Neurosurgical unit
- ☐ Adult/General HDU
- ☐ Not known
- ☐ Other, *specify* _____

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 D D/M M/Y Y H H:M M *(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 D D/M M/Y Y H H:M M *(24 hr clock)* ☐ *Not recorded*

6.2.6 Reason for transfer *(please tick all that apply)*

- ☐ No paediatric facilities
- ☐ No ICU facilities in hospital
- ☐ No PICU bed available in hospital
- ☐ No general ICU bed available in hospital
- ☐ Access to paediatric neuroscience facilities
- ☐ Paediatric surgery
- ☐ Receiving hospital close to child's home
- ☐ Other, *please specify* _____
- ☐ Not recorded
- ☐ Not known

6.2.7 Means of transfer

- ☐ Specialist PICU transport team
- ☐ Local team
- ☐ Paramedic Ambulance
- ☐ Ambulance (Non paramedic)
- ☐ Private/public transport
- ☐ Other land, *please specify* _____
- ☐ Helicopter (Paramedic/medic)
- ☐ Other airborne, *please specify* _____
- ☐ Not recorded
- ☐ Not known

6.2.8 Additional transfer information *(e.g. reason for delay)*

Please use the additional sheet provided on page 7 if there is not enough room to complete your answer

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 D D / M M / Y Y ☐ *Not recorded*

6.3.3 Time of discharge H H : M M *(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 D D / M M / Y Y ☐ *Not recorded*

6.4.2 Time of death H H : M M *(24 hr clock)* ☐ *Not recorded*

6.4.3 Place of death

☐ General children's ward
☐ Paediatric Intensive Care Unit (PICU)
☐ Paediatric Neurosurgical unit
☐ Paediatric High Dependency Unit (PHDU)
☐ Specialist children's ward, *specify* _____
☐ General/Adult ICU
☐ Adult Neurosurgical unit
☐ Adult High Dependency Unit (HDU)
☐ Emergency Department
☐ Other, *specify* _____
☐ Theatre
☐ Short stay Unit
☐ Observation unit
☐ Home
☐ 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
100	General Surgery	302	Endocrinology
110	Trauma & Orthopaediacs	303	Clinical Haematology
120	Ear Nose Throat (ENT)	400	Neurology
145	Oral & Maxillo Facial Surgery	401	Clinical Neuro-Physiology
150	Neurosurgery	420	Paediatrics
170	Cardiothoracic Surgery	421	Paediatric Neurology
171	Paediatric Surgery	450	Dental Medicine Specialities
180	Emergency Medicine	460	Medical Opthamology
190	Anaesthetics	600	General Medical Practice
192	Critical Care Medicine	601	General Dental Practice
193	Paediatric Intensive Care	810	Radiology
300	General Medicine	823	Haematology
301	Gastroenterology	000	Other (Surgical or Medical)

CODE	CLINICIAN
CONS	Consultant
SG	Staff Grade
CF	Clinical Fellow
AS	Associate Specialist
ST *+ 1-8*	Single Training *e.g. ST4*
SpR *+ year*	Specialist Registrar *e.g. SpR2*
FY *+ year*	Foundation year *e.g. if year 1, enter FY1*
ENP	Emergency Nurse Practitioner
APNP	Advanced Paediatric Nurse Practitioner
ATNC	Nurse - Advance Trauma Cert
RSCN	Nurse - RSCN
NURS	Nurse - General
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***
⇒ 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)*

Definition of **'admission'** can be found on the front of this form

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	
S02	**Fracture of skull and facial bones, *e.g.***
	Fracture of vault of skull
	Fracture of base of skull
	Multiple fractures involving skull and facial bones
	Fractures of other skull and facial bones
S04	**Injury of cranial nerves, *e.g.***
	Injury of optic nerve and pathways
	Injury of oculomotor nerve
S06	**Intracranial injury, *e.g.***
	Concussion
	Traumatic cerebral oedema
	Diffuse brain injury
	Focal brain injury
	EDH (Extra Dural Haematoma)
	Traumatic subdural/subarachnoid haemorrhage
	Intracranial injury with prolonged coma
	Other intracranial injuries
	Intracranial injuries - unspecified
S07	**Crushing injury of head, *e.g.***
	Crushing injury of the face
	Crushing injury of the skull
S08	**Traumatic amputation of part of head, *e.g.***
	Traumatic amputations
	Multiple injuries of head

Examples of types of head injuries to be EXCLUDED	
S00	**Superficial Injuries, *e.g.***
	Superficial injury of scalp
	Contusion of eyelid and periocular area
	Other superficial injuries of eyelid and periocular area
	Superficial injury of nose, ear, lip, or oral cavity
S01	**Open wound of head, *e.g.***
	Scalp, eyelid and periocular area, nose, ear, cheek & temporomandibular area, lip & oral cavity.
S02	**Fracture of skull and facial bones, *e.g.***
	Fracture of tooth, mandible, nasal bones, orbital floor, malar & maxillary bones.
S03	**Dislocation, sprain & strain of joints & ligaments of head,**
	Dislocation of jaw, septal cartilage of nose, septal cartilage of nose, or tooth. Sprain and strain of jaw.
S04	**Injury of cranial nerves, *e.g.***
	Injury of trochlear nerve, trigeminal nerve, abducent nerve, facial nerve
S05	**Injury of eye and orbit, *e.g.***
	Injury of conjunctiva and corneal abrasion
	Contusion of eyeball and orbital tissues
	Ocular laceration and rupture with prolapse
	Penetrating wound of orbit, or eyeball
	Avulsion of eye
S08	**Traumatic amputation of part of head, *e.g.***
	Avulsion of scalp
	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
Carol Hay, Regional Manager
Box 111, Room 414, Clinical School
Addenbrooke's Hospital, Hills Road
Cambridge, CB2 0SP

T: 01223 330 356 or 351 E: carol.hay@cmace.org.uk

CMACE East Midlands and Yorkshire and The Humber Office
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CMACE London and South East Office
Dave Kimani, Administrative Assistant
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NW1 5SD

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CMACE North East Office (FAO Marjorie Renwick)
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