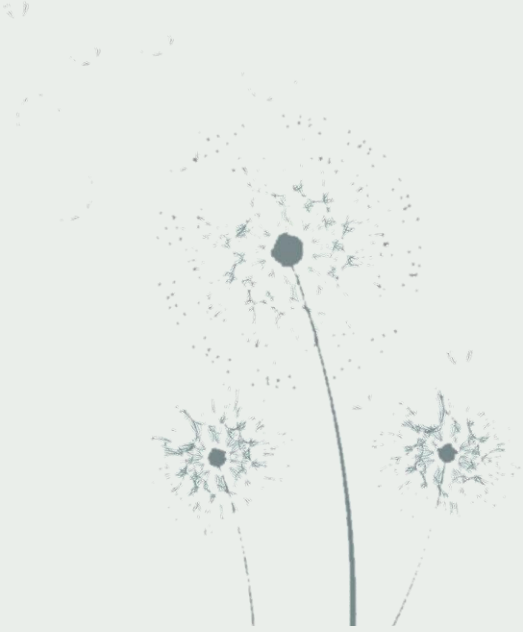
Child Death Overview Panel (CDOP) Annual Report

April 2021 - March 2022

North & South of Tyne

Contents



Foreword

Child Death Overview Panel Independent Chairperson (North & South of Tyne)

Welcome to the second annual report of the North and South of Tyne Child Death Overview Panel (N&S Tyne CDOP), which contains a summary of the activity carried out by the panel, activity which seeks to drive improvements in children and young people's health across the 6 areas represented: Gateshead, Newcastle, Northumberland, North Tyneside, South Tyneside and Sunderland.

The Child Death process requires agencies to undertake a review process prior to the panel review. Thanks must go to all those frontline staff and their managers involved in this process, without whom we could not fulfil our task. Frontline staff are the 'human face' of the child death review process, supporting families' at the most difficult time of their lives.

The statutory task of the multi-agency panel lies in its ability to scrutinise the circumstances surrounding each child's death and where appropriate, to provide challenge to the agencies involved to further enhance the learning, as well as make recommendations to the appropriate agencies to improve service delivery and patient experience.

The re-constituted panel has now been functioning for two years, in which attendance has been excellent. Meeting virtually has been a challenge, however anecdotally we are aware that virtual meetings have facilitated a wider diversity of professionals' attendance at Joint Agency Response meetings (JARs) and Child Death Review Meetings (CDRMs) which can only lead to improved information sharing and learning.

The North and South of Tyne panel met 8 times within the timeframe of this annual report (April 2021 - March 2022) and has enjoyed very good multi-agency attendance. We have continued to welcome observers to the panel from the constituent agencies and there have been 5 such observers this year from nursing, medicine and safeguarding.

Sheila Moore, MA, RGN, DN, HV
Independent Chair

1 Introduction

1.1 The death of a child is a devastating loss which profoundly affects all those involved. Since April 2008 all deaths of children up to the age of 18 years, excluding stillbirths and planned terminations are to be reviewed by CDOP to comply with the statutory requirement set out in Working Together 2018[1]. In the event of a birth which is not attended by a healthcare professional, child death partners may carry out initial enquiries to determine whether the baby was born alive. If the baby was born alive then the death must be reviewed.

1.2 The Children Act 2004[2] requires Child Death Review Partners, (5 CCGs and 6 Local Authorities in our footprint) to ensure arrangements are in place to carry out child death reviews, including the establishment of a CDOP. The reviews are conducted in accordance with Working Together 2018 alongside the Statutory and Operational Guidance (England) 2018[3].

1.3 The North and South of Tyne CDOP panel is multi-agency and the process is carried out for all children resident in the 6 Local Authority areas listed in the foreword. Legislation allows for CDR partners to make arrangements for a review of a death of a child not normally resident there. This process needs to be pragmatic with consideration given to where the most learning can take place.

1.4 In April 2019 the National Child Mortality Database[4] (NCMD) became operational and is populated directly with the relevant data from eCDOP, a cloud-based information management system commissioned by the CDR partners for use across our footprint.

1.5 The purpose of the panel is to:

- Ascertain why a child has died by a thorough but proportionate review of the facts and circumstances surrounding the death
- Determine the contributory and modifiable factors
- To make recommendations to all relevant organisations where actions have been identified which may prevent further deaths or promote the health, safety and well-being of children
- Provide detailed data to NCMD which they analyse nationally and produce regular reports e.g. on the impact of deprivation on child deaths.
- Produce an annual report highlighting local trends and patterns and any actions taken by the panel
- Contribute to the wider learning locally, regionally and nationally.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

[2] https://www.legislation.gov.uk/ukpga/2004/31/enacted

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf

[4] https://www.ncmd.info/

The CDOP is not commissioned to undertake public health campaigns or deliver interventions arising from the learning from reviews, rather it relies on its' partners in the Health and Well-being Boards and the Safeguarding Children Partnerships to incorporate the lessons learned into policy and develop appropriate interventions.

2 The Process of the Child Death Overview Panel across North & South of Tyne

Northumberland, North Tyneside, Newcastle, Gateshead, South Tyneside and Sunderland work together via the North and South of Tyne Child Death Overview Panel (CDOP) to review the death of every child who normally resides in each of these areas, regardless of where the death occurs. This document reports on all the children whose deaths were reviewed in 2021/22, regardless of the year in which the child died.

When a child dies, an appropriate clinician will, in liaison with other professionals make immediate decisions on whether a Medical Certificate of Cause of Death (MCCD) can be issued or whether a referral is required to the coroner.

Where a death is, for example, from a life-limiting illness, the death will be registered in the usual way and the family is offered support. Information is gathered from professionals involved, which is then collated and presented to the Child Death Overview Panel.

Where a death requires a series of rigorous investigations, including a post-mortem, a multi-agency meeting, known as a Joint Agency Response (JAR) is held to establish, as far as possible, the cause of death and plan future support for the family. A Child Death Review meeting (CDRM) follows once all the information is available and is then collated and presented to the Child Death Overview Panel.

The CDOP will in each case classify the cause of death, identify contributory factors, identify any modifiable factors (those which can be changed through national or local interventions) and make recommendations to prevent future similar deaths, or improve the safety and welfare of children in the local area and further afield.

The Children and Social Work Act 2017[5] ended the requirement for serious case reviews when the LSCB converted into the new multi-agency safeguarding arrangement. Following the ending of the LSCB the new Multi-Agency Safeguarding Arrangements must comply with the requirements outlined in the legislation and Working Together 2018 to undertake, Child Safeguarding Practice Reviews (CSPRs) which can be locally or nationally led and overseen by a national panel. The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children.

The CDOP need to consider whether the criteria for a local or national SPR might be met in certain cases, even if it has already been considered by the SCP, and to make recommendations appropriately.

[5] https://www.legislation.gov.uk/ukpga/2017/16/contents/enacted

Learning Reviews can also be undertaken. In 2021/2022 there were two cases subject to a SCPR and one case subject to a learning review.

The Child Death Review process recommends that panels undertake themed panels. Two themed neonatal panels were held and panel members were very positive around the scope of learning which took place whilst focusing on one category of child death.

If the CDOP is notified of the death of a child with an identified learning disability or the likelihood of a diagnosis this information is shared with the Learning Disabilities Mortality Review (LeDeR)[6] Programme via the online referral process. Further liaison takes place to share core data to ensure the CDOP supports the LeDeR Programme.

3 Membership of the Child Death Overview Panel

Named Representative	Agency/Title
Sheila Moore	Independent Chair
Jill Rennie	North of Tyne CDOP Coordinator
Dr Richard Hearn	Consultant Neonatologist NUTH
Dr Anna Thorley	Designated Doctor Child Deaths Newcastle
Dr Stephen Bruce	Designated Doctor Child Deaths Northumberland & North Tyneside
Dr Maryam Rehan	Designated Doctor Child Deaths Gateshead
Dr Sunil Gupta	Designated Doctor Child Deaths South Tyneside
Dr Carl Harvey	Designated Doctor Child Deaths Sunderland
Nichola Howard	Named Professional Safeguarding North East Ambulance Service
Trina Holcroft	Designated Nurse Safeguarding Children, Newcastle and Gateshead
Jan Hemingway	Designated Nurse Safeguarding Children, North Tyneside

[6] https://leder.nhs.uk/

Jenna Wall/Lesley Heelbeck	Head of Midwifery Northumbria/Head of Midwifery Gateshead
Louise Cass-Williams	Northumbria Police
David Garner	Practice Manager ISIT (Social care)
Alison Fry	Children's Services Manager
Wendy Burke	Director of Public Health (DPH) North Tyneside Council
Tom Hall	Director of Public Health (DPH) South Tyneside Council
Dr Therese Hannon	Consultant Obstetrician (Themed Panel Member)
Tracey Hadaway	South of Tyne CDR Coordinator

4 Examples of actions taken to reduce child deaths across the CDOP footprint.

4.1 Primary Care

As a result of a child's death a primary care practice introduced a system to highlight vulnerable young people who were not requesting repeat prescriptions for long term mental health conditions. The preliminary findings after a six-month review identified five such cases.

When primary care has undertaken pieces of work as above, the learning is shared with other practices via GP TeamNet, email and peer review sessions.

4.2 Midwifery

The maternity service of Northumbria Healthcare NHS Trust reviewed the 2020/21 report and completed a gap analysis of ongoing public health workstreams to ensure the modifiable factors were being addressed.

An area of focus was safe sleeping practices, and as a result the maternity service planned their educational 'Theme of the Month' around safe sleeping practices. This includes educational displays in all staff areas throughout the service, an update of the Head of Midwifery monthly newsletter, a parent education drive with information shared via social media platforms and also in patient facing areas in the maternity units.

A survey monkey questionnaire was shared with parents to gather data regarding the information midwifery staff were providing, whether this was adequate, and which areas needed further development (interestingly this was around safe bed sharing practices…). The results of this survey fed into the gap analysis and action plan and as a result patient information has been updated and will be transitioned onto BadgerNet from April 2022.

4.3 NCMD Webinars

The 58 CDOPs contribute data nationally which is then used to develop themed reports and inform professionals and policy makers, highlights from this work includes:

- Continued sharing of real-time child death data with NHS England to support and inform the national response to COVID-19 pandemic.
- Child Mortality and Social Deprivation Report May 202, supported by a webinar
- Suicide in Children and Young People Oct 2021, supported by a webinar

- Child deaths in England after Covid-19 infection during the first pandemic year
- How to complete a reporting form effectively, supported by a webinar
- The Role of the Key worker, supported by a webinar
- Safety notices shared on super strong magnets and baby slings: these come about when the NCMD receive a notification of a child's death and they believe the risk to other children is great enough to warrant a national alert.

5. Deaths Notified to North & South of Tyne CDOP

There is a well-established and robust system for notifying the CDOP of the death of a child, all relevant agencies have access to the electronic eCDOP, in line with the statutory requirements to notify all child deaths 0-17 years of age immediately after the death of the child. Multi-agency data is then transferred to NCMD, reducing duplication.

Table 5.1 – Total number of notifications of deaths

	2020/21	2021/22
Northumberland	16 (21%)	19 (21%)
North Tyneside	7 (9%)	7 (8%)
Newcastle	19 (25%)	19 (21%)
Gateshead	13 (17%)	13 (14%)
South Tyneside	5 (7%)	12 (13%)
Sunderland	15 (20%)	12 (13%)
Out of Area	0	9 (10%)
North and South of Tyne Total	75	91

There were 91 deaths notified to the CDOP in 2021/2022, compared with 75 the previous year, this number differs from the number of cases which the panel reviews as the preceding child death review process, prior to the CDOP meeting can take several months, particularly if there are police or coronial processes to be concluded.

Table 5.2 – Age of child at time of notification of death

	2020/21	2021/22
0-27 days	30 (40%)	33 (36%)
28 days- 364 days	14 (17%)	22 (24%)
1 year-4 years	8 (11%)	15 (16%)
5-9 years	6 (8%)	6 (7%)

10-14 years	7 (9%)	7 (8%)
15-17 years	10 (13%)	8 (9%)
North and South of Tyne Total	75	91

Table 5.3 - Place of Death identified at notification

	2020/21	2021/22
Hospital	53 (71%)	71 (78%)
Home	15 (20%)	18 (20%)
Hospice	1(1%)	2 (2%)
Public Area	5 (7%)	0
Private Care Home	1(1%)	0
North and South of Tyne Total	75	91

In 2021/2022 71 (78%) of the deaths occurred in a hospital setting, with 18 (20%) occurring at home.

Table 5.4 – Gender of child at time of notification

	2020/21	2021/22
Male	35 (47%)	61 (67%)
Female	40 (53%)	29 (32%)
Indeterminate	0	<5
North and South of Tyne Total	75	91

Table 5.5 - Number of death notifications by ethnicity

Ethnicity (Broad)	2020/21	2021/22
White	64 (85%)	73 (80%)

Mixed	0	2 (2%)
Asian	7 (9%)	11 (12%)
Black	3 (4%)	2 (2%)
Other	1 91%)	3 (3%)
Unknown	0	0
North and South of Tyne Total	75	91

6. Deaths which have been reviewed and cases closed

Table 6.1 – Total number of deaths reviewed

	2020/21	2021/22
Northumberland	20 (24%)	10 (14%)
North Tyneside	5 (6%)	10 (14%)
Newcastle	23 (28%)	17 (23%)
Gateshead	16 (20%)	9 (12%)
South Tyneside	4 (5%)	8 (11%)
Sunderland	14 (17%)	17 (23%)
Out of Area	0	2 (3%)
North and South of Tyne Total	82	73

The panel reviewed two cases from out of the area, i.e. children who were resident in another country. One of the acute hospitals in our footprint is a tertiary facility providing specialist services and cares for children from a wide catchment area. The cases were brought to panel as the clinicians involved felt there was learning for the system.

Table 6.2 – Age of child at time of death

	2020/21	2021/22
0-27 days	37 (45%)	26 (36%)

28 days- 364 days	13 (16%)	14 (19%)
1 year-4 years	10 (12%)	12 (16%)
5-9 years	7 (9%)	4 (5%)
10-14 years	7 (9%)	6 (8%)
15-17 years	8 (10%)	11 (15%)
North and South of Tyne Total	82	73

The largest number of reviews were in the 0-27 days category 26 (36%) followed by 28-364 days 14 (19%)

Table 6.3 - Place of Death

	2020/21	2021/22
Hospital	66 (80%)	49 (67%)
Home	9 (11%)	19 (26%)
Hospice	3 (4%)	1 (1%)
Public Area	3 (4%)	4 (5%)
Private Care Home	1 (1%)	0
North and South of Tyne Total	82	73

Table 6.4 – Gender of child of cases reviewed and closed

	2020/21	2021/22
Male	46 (56%)	37 (50%)
Female	36 (44%)	36 (49%)
North and South of Tyne Total	82	73

Table 6.5 - Number of deaths by ethnicity of cases reviewed and closed

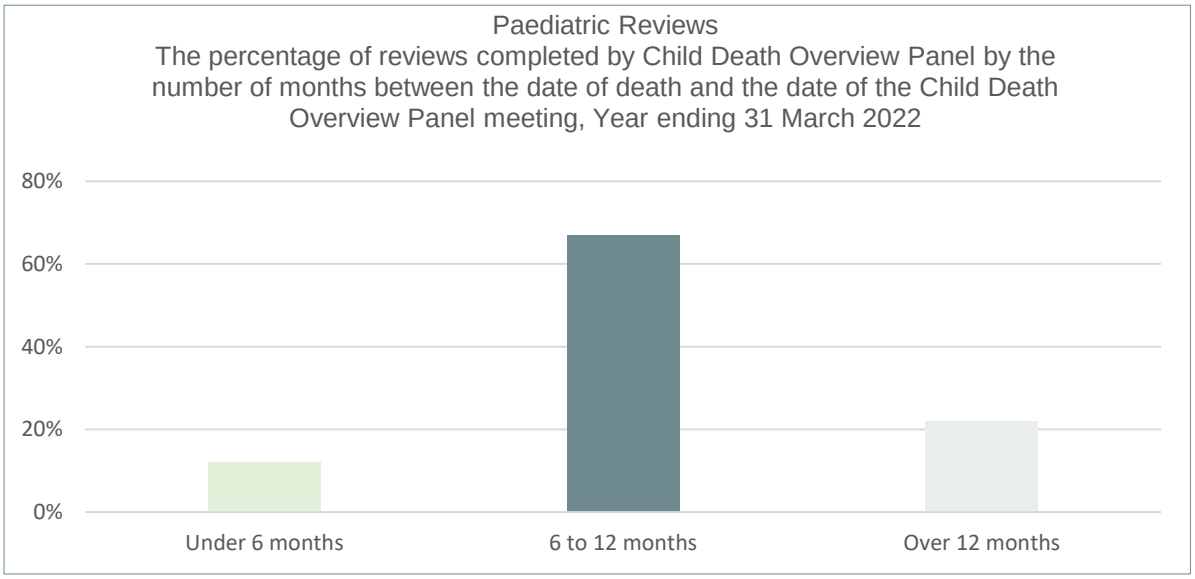
Ethnicity (Broad)	2020/21	2021/22

White	71 (87%)	59 (81%)
Mixed	2 (2%)	1 (1%)
Asian	8 (10%)	6 (8%)
Black	1 (1%)	3 (4%)
Other	0	2 (3%)
Unknown	0	2 (3%)
North and South of Tyne Total	82	73

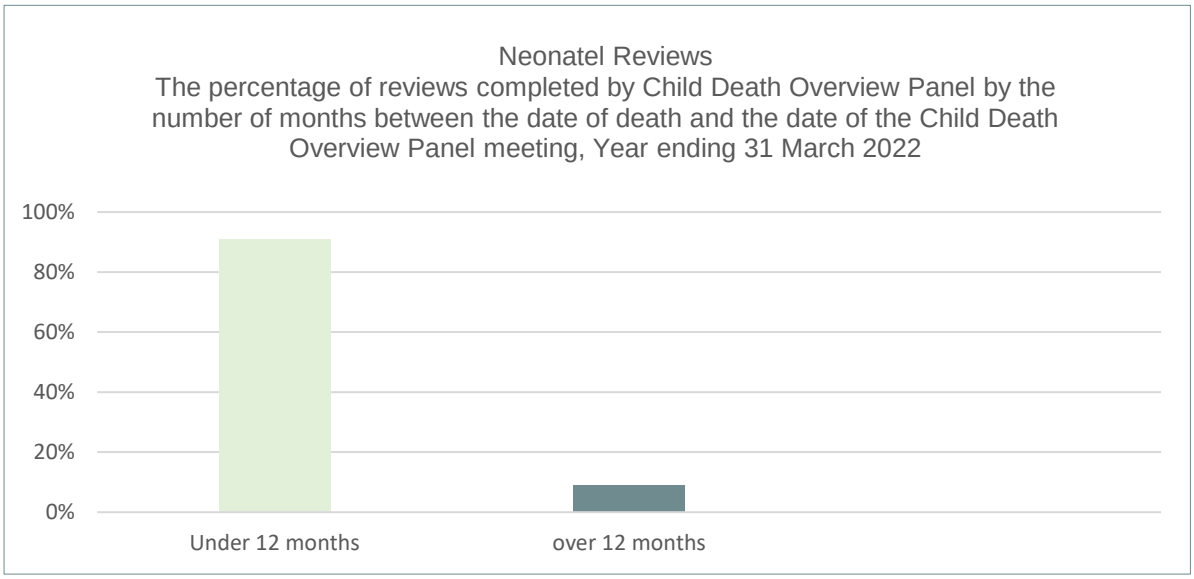
Table 6.6 - Number of reviews at each meeting 2021/22

May	June	June Themed	Aug	Sep	Nov	Jan Themed	Feb	Total
9	12	8	9	2	4	14	15	73

Table 6.7 - Duration of Reviews 2021/22



In this year 51 paediatric deaths were reviewed, 6 (12%) of reviews were finalised within 6 months of the child's death, while 34 (67%) were completed between 6-12 months and 11 (22%) took over a year.



In this year 22 neonatal deaths were reviewed within 2 themed panels, 20 (91%) were reviewed within the 12-month timescale and 2 (9%) took over a year

There are several factors that may contribute to a longer length of time between the death of a child and the final CDOP review. Examples are the return of reporting forms, the receipt of the final post-mortem report, undertaking a criminal investigation or a Child Safeguarding Practice Review and receipt of the final report from the local child death review meeting. In addition, on occasion when the outcome of a Coroner's inquest is awaited, there may be a longer delay before the panel can finalise the review process.

The panel engaged in discussion with the Regional Pathology department to attempt to resolve the delays in PM reports which was impacting on the panels' ability to review and close cases. There is a national shortage of forensically trained paediatric pathologists so a pathway was developed to ensure that all post mortems, including the reports, are completed in line with national guidance. Some of the work has been outsourced and the remainder is dealt with in house with strenuous efforts being made to fill a current vacancy. These arrangements will be monitored closely.

7. Modifiable Factors

The review process is required to identify deaths where modifiable factors occur, in order that agencies learn lessons, improve practice and ultimately prevent further deaths.

Of the 73 cases reviewed in 2021 /2022, modifiable factors were identified in 28 (38%)

A modifiable factor is defined as something which: “may have contributed to the death of the child and which, by means of locally and nationally achievable interventions, could be modified to reduce the risk of future child deaths”.

There is a degree of subjectivity in this matter which is decided on a case-by-case basis and is reliant on the thorough completion of national CDOP reporting forms by the clinicians. This takes place after the Child Death Review Meeting (CDRM) where all the relevant professionals who know the family share knowledge of the child's life and the

circumstances of the death. Four domains are used to categorise the information with a corresponding level of relevance (0-2):

Domain A: Factors intrinsic to the child

Domain B: Factors in social environment including family and parenting capacity

Domain C: Factors in the physical environment

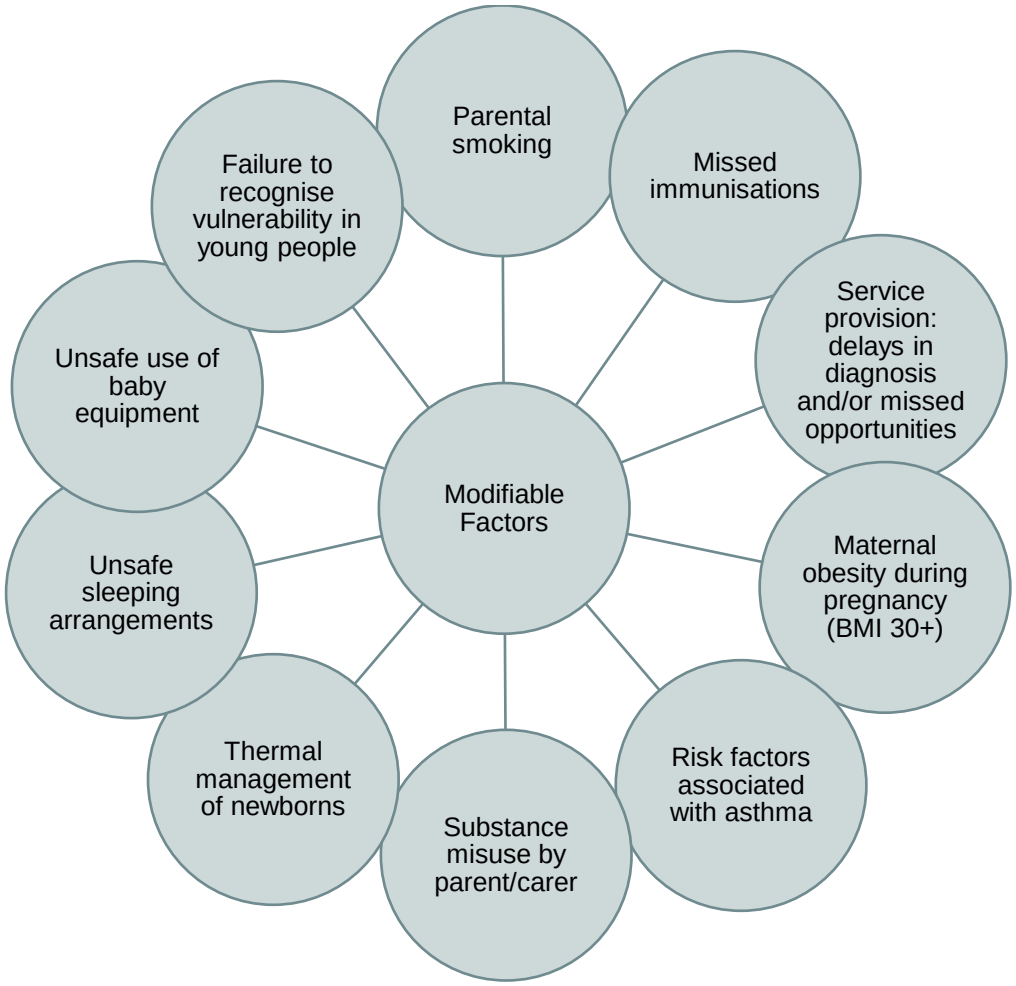
Domain D: Factors in service provision.

NCMD are working to develop guidance on the identification of modifiable factors to assist CDOPs.

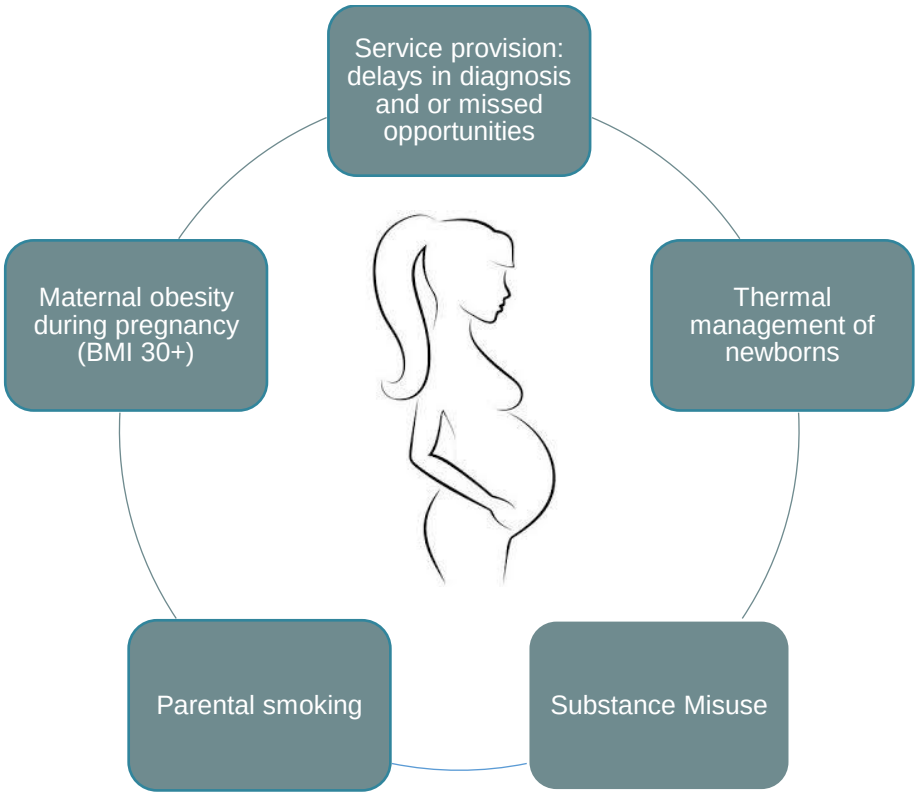
It is worth noting that the child death process also creates an opportunity at the meetings held before the panel review (Joint Agency Response Meetings, Morbidity and Mortality and Child Death Review Meetings) for services to identify other smaller, micro-changes to practice, e.g. a need for workplace training or amendments to internal policies and procedures.

Table 7.1 - Numbers and % of child deaths where modifiable factors were identified

Area	2020/21 - 2021/22							
	Total number of cases		No modifiable factors		Modifiable factors		% with modifiable factors	
	20/21	**21/22**	20/21	**21/22**	20/21	**21/22**	20/21	**21/22**
Newcastle	23	**17**	18	**12**	5	**5**	22%	**29%**
Northumberland	20	**10**	11	**4**	9	**6**	45%	**60%**
North Tyneside	5	**10**	5	**9**	0	**1**	0%	**10%**
Gateshead	16	**9**	10	**5**	6	**4**	37%	**44%**
South Tyneside	4	**8**	2	**3**	2	**5**	50%	**63%**
Sunderland	14	**17**	9	**10**	5	**7**	36%	**41%**
Out of Area	0	**2**	0	**2**	0	**0**	0%	**0%**
North & South of Tyne	82	**73**	55	**45**	27	**28**	33%	**38%**



- Parental smoking
- Missed immunisations
- Service provision: delays in diagnosis and/or missed opportunities
- Maternal obesity during pregnancy (BMI 30+)
- Risk factors associated with asthma
- Substance misuse by parent/carer
- Unsafe sleeping arrangements
- Unsafe use of baby equipment
- Failure to recognise vulnerability in young people
- Thermal management of new-born babies.



7.2 Maternal Obesity in Pregnancy

A modifiable and relevant factor highlighted by the North and South of Tyne CDOP is mother's raised body mass index (BMI) during pregnancy. For most adults, an ideal BMI is in the 18.5 to 24.9 range (healthy weight range). The NHS defines the BMI[7] categories as:

- below 18.5 - underweight
- between 18.5 and 24.9 - healthy weight range
- between 25 and 29.9 - overweight range
- between 30 and 39.9 - obese weight range
- 40 and over - severely obese weight range

Being overweight increases the risk of complications for pregnant women and baby[8]. The higher a woman's BMI, the higher the chance of complications. Problems for baby can include being born prematurely and an increased risk of stillbirth (from an overall risk of 1 in 200 in the UK to 1 in 100 if mother has a BMI of 30 or more).

The increasing chances of complications are in relation to:

- miscarriage - the overall chance of miscarriage under 12 weeks is 1 in 5 (20%); for women with a BMI over 30, the chance is 1 in 4 (25%)
- gestational diabetes - women with a BMI of 30 or above, are 3 times more likely to develop gestational diabetes than women who have a BMI below 25

[7] https://www.nhs.uk/conditions/obesity/

[8] https://www.nhs.uk/conditions/pregnancy-and-baby/overweight-pregnant/

- high blood pressure and pre-eclampsia - women with a BMI of 30 or above at the beginning of their pregnancy, have a chance of pre-eclampsia which is 2 to 4 times higher than that of women who have a BMI below 25
- blood clots - all pregnant women have a higher chance of blood clots compared to women who are not pregnant, for women with a BMI of 25 or above, the chance is increased further
- the baby's shoulder becoming "stuck" during labour (sometimes called shoulder dystocia)
- heavier bleeding than normal after the birth (post-partum haemorrhage)
- having a baby weighing more than 4kg (8lb 14oz) - the overall chance of this for women with a BMI of 20 to 30 is 7 in 100 (7%); for women with a BMI of above 30, the chance is doubled to 14 in 100 (14%)
- women are also more likely to need an instrumental delivery (forceps or ventouse), or an emergency caesarean section

7.3 Smoking

Smoking continues to have a negative impact on the general health of children and remains a key modifiable factor for child deaths in the North East. Depending on the nature of the death, the CDOP collates information regarding the smoking status during the antenatal period, including maternal smoking in pregnancy and household members to monitor women who are exposed to harmful effects of environmental tobacco smoke during pregnancy.

Smoking in pregnancy has well known detrimental effects for the growth and development of baby and the health of the mother. Smoking during pregnancy can cause serious pregnancy related health problems including complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy (SUDI). Maternal smoking in pregnancy and/or parental household smoking was the most common occurring modifiable factor which the CDOP deemed a significant relevant factor in relation the cause of death. A smoke-free home is the best way of protecting babies and children.

7.4 Sudden & Unexpected Death in Infancy/Childhood (SUDI/SUDC)

Deaths categorised as a sudden unexpected, unexplained death where the pathological cause of death was recorded as either ‘sudden infant death syndrome (SIDS)’ or remains ‘unascertained’, continue to feature multiple modifiable factors relating to forms of unsafe sleeping arrangements. Unsafe sleeping arrangements such as co-sleeping, are particularly dangerous if the parent/carer has consumed alcohol or ingested substances, which may limit their awareness. Other known risk factors include co-sleeping with babies born prematurely or those with a low birth weight, overheating, covering baby’s face or head while sleeping, loose bedding and falling asleep with baby on a sofa or in an armchair.
In deaths categorised as sudden unexpected, unexplained death, the CDOP highlighted several modifiable factors identified including:

- Parental smoking and/or other household smokers
- Unsafe sleeping arrangements such as co-sleeping where the carer has used alcohol or drugs

Dissemination of the learning from reviews

Panel members are tasked with taking the learning from these cases and sharing it widely within their organisations in order that staff in all the constituent agencies are aware of the risk factors when supporting and advising parents and carers. The learning is also included in the training package which is delivered to staff groups.

8 Categories of Child Deaths

The categories below are determined by the DfE and every CDOP nationally follows them.

Table 8.1 - Category of child deaths

Category		2020/2021	2021/2022
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	1
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.	4	7
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).	2	5
4	**Malignancy -** Solid tumours, leukaemia & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	7	9
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.	3	6
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.	5	1

7	**Chromosomal, genetic and congenital anomalies** - Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.	18	18
8	**Perinatal/neonatal event** - Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intra-partum 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).	32	17
9	**Infection** - Any primary infection (i.e., 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.	5	2
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).	4	7