NOCA National Office of Clinical Audit

NPMR National Paediatric Mortality Register

National Paediatric Mortality Register

Important:
Please tick relevant boxes. Please ensure that all sheets are stapled together.

Patient Addressograph

ATTACH LABEL HERE

GREY FIELDS ARE MANDATORY **ALL OTHER FIELDS ARE OPTIONAL**

MRN	Local ID

PATIENT DETAILS

National Number	IHI Number			
First Name	If Unavailable, please use 'Baby Surname'			
Last Name				
Date of Birth	DD/MM/YYYY	Sex at Birth	☐ Female ☐ Male	☐ Indeterminate ☐ Unknown
Address 1				
Address 2		Address 3		
Address 4		Address 5		
Eircode				
Date of Death	DD/MM/YYYY			

ADDITIONAL PATIENT DETAILS

Ethnicity Known	☐ Unknown ☐ White - Irish ☐ White – Irish Traveller ☐ White – Irish Roma ☐ White – Any other White background Please specify	☐ Black or Black Irish – African ☐ Black or Black Irish – Any other black background Please specify ☐ Asian or Asian Irish – Chinese ☐ Asian or Asian Irish – Indian / Pakistan/ Bangladeshi ☐ Asian or Asian Irish - Any other Asian background Please specify	☐ Arabic ☐ Mixed or Other Group background Please specify ☐ Information Unavailable ☐ Choose not to respond (.e.g to avoid delay in notification)

UNDER 19 MORTALITY NOTIFICATION FORM

Address of the deceased (country)		If Country = Ireland specify Address of the deceased (county)	
Notifying Body	☐ Hospital ☐ Other, please specify	Date of Death	DD/MM/YYYY
		Time of Death (24-hour clock)	
Is the country of birth information available	☐ Yes ☐ No	Country of birth	
Where in the hospital did the child or young person die?	**Hospital** ☐ Neonatal Ward ☐ Paediatric Regional High Dependency Unit ☐ Paediatric Critical Care Unit ☐ Adult Critical Care Unit ☐ Emergency Department ☐ Ward ☐ Designated Pallative Care Space ☐ Theatre ☐ Transferred to another facility overseas for care ☐ Other 'in hospital: Please specify	**In Transit (Medical Transport)** ☐ Pre-hospital Emergency Services ☐ Transfer between hospitals ☐ Transfer home	**Community** ☐ At home ☐ Homeless accommodation ☐ Public place ☐ School ☐ Hospice ☐ Other, Please specify ☐ Information Unavailable
Is a post-mortem occurring?	☐ No	☐ Yes, Coroner's postmortem	☐ Yes, Hospital postmortem ☐ Don't know

MRN	Local ID

Suspected Cause of Death			
Were any of the following events known to have occurred? *(Tick all that apply)*	☐ Neonatal Condition ☐ Acute Asthma ☐ Infection ☐ Acute Epilepsy ☐ Poisoning ☐ Road traffice collison ☐ Drowning	☐ Apparent Suicide ☐ Apparent Homicide ☐ Fall ☐ Accidental Strangulation ☐ Fire/Burns ☐ Other unintentional injury, Please specify ☐ Sudden unexpected death in infancy and childhood	☐ Death from malignancy ☐ Acute metabolic/diabetic ketoacidosis ☐ Cardiac condition (congenital or acquired) ☐ Death of a Child with a life limiting condition ☐ Chromosomal, genetic or congenital anomaly (excluding cardiac conditions) ☐ None of the above

NEONATES (< 29 DAYS)				
Weight of newborn at time of birth (in grams)				
Gestation at delivery (completed number of weeks)		Gestation at delivery (completed number of days)		
Place of Birth	☐ Hospital	☐ Born before arrival at hospital	☐ Domiciliary birth (planned home birth)	☐ Information unavailable

SUDI/SUDC (SUDDEN UNEXPECTED DEATH IN INFANCY OR CHILDREN < 5 YEARS)			
Position of child in cot/bed/other when found dead	☐ Back ☐ Prone	☐ Side ☐ Information Unavailable	☐ Not Applicable
Location in which child was found dead	☐ Cot ☐ Bed	☐ Sofa/armchair ☐ Other, please specify	☐ Information Unavailable ☐ Not Applicable
Child co-sleeping with adult at the time of death	☐ Yes ☐ No	☐ Information Unavailable ☐ Not Applicable	
Child co-sleeping with another child at the time of death	☐ Yes ☐ No	☐ Information Unavailable ☐ Not Applicable	

INFORMANT DETAILS		
INFORMANT DETAILS		
Informant Name		
Professional registration group	☐ Irish Medical Council (IMC) ☐ Nursing and Midwifery Board of Ireland (NMBI)	☐ CORU (Regulating Health and Social Care Professionals) ☐ Other Please specify
Informant preferred contact number		
Informant email		
Indicate if the informant is the consultant overseeing the patients care in the hospital	☐ Yes ☐ No	
CONSULTANT DETAILS (if not informant)		
Name of consultant - overseeing patients care in hospital		
Consultant overseeing patients care - Telephone number		
Consultant overseeing patients care - Email address		
FORM COMPLETION		
Date form Completed		Form Completed by