This form is used in the child death review process to gather detailed information about children who die with an oncology condition. Its primary purpose is to enable CDOP to review all children's deaths in this category in their area in order to understand patterns and factors contributing to children's deaths. Please complete those questions on which you hold information. If you do not have information for a particular item, please tick “Not known”.

Information on this form will be shared with other professionals for the purposes of the child death review process. All professionals are entitled to share this information without contravening laws on data protection. All information gathered will be stored securely and statutory safeguards (s251) are in place to allow the legal transfer, storage, analysis of identifiable data.

**Identifying details - to be removed for the purposes of anonymisation prior to discussion at the CDOP:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Date of birth(dd/mm/yyyy) |  / /  |
| URN |  | Date and time of death | Date: / / Time: **:** (24hr) |
| Postcode |  |

|  |  |
| --- | --- |
| Which primary diagnosis sub-category did this child fall into? *(Please choose* ***ONE*** *option)* | ☐ Leukaemias, myeloproliferative diseases, and  myelodysplastic diseases☐ Lymphomas and reticuloendothelial neoplasms  (including mitochondrial)☐ CNS and miscellaneous intracranial and intraspinal neoplasms ☐ Neuroblastoma and other peripheral nervous cell  tumours ☐ Retinoblastoma ☐ Renal tumours ☐ Hepatic tumours☐ Malignant bone tumours☐ Soft tissue and other extraosseous sarcomas☐ Germ cell tumours, trophoblastic tumours, and  neoplasms of gonads☐ Other malignant epithelial neoplasms and  malignant melanomas☐ Other and unspecified malignant neoplasms |
| Please specify age when first diagnosed: | ☐ Antenatal diagnosis☐ Birth to 12 months☐ 1 – 4 years ☐ 5 – 9 years☐ 10 – 14 years ☐ 15 – 17 years  |
| Please specify the stage of the disease at the point of diagnosis? | ☐ Localised☐ Metastatic☐ Unstageable |
| What was the route to diagnosis? | ☐ Pregnancy or early postnatal screening ☐ Two Week Wait ☐ GP referral ☐ Outpatient ☐ Inpatient☐ Emergency☐ Not known |
| What was the approximate interval, in days, weeks or months, from date of symptom onset to date of diagnosis?  |  |
| Was there a delay in referral for cancer diagnosis? | ☐ Yes *(please give reason why)*☐ No ☐ Any other comments:  |
| Was the 31 day wait target met? | ☐ Yes☐ No☐ Not known☐ Not applicable |
| Was the 62 day wait target met? | ☐ Yes☐ No☐ Not known☐ Not applicable |
| Was there a delay in the diagnosis of this condition?  | ☐ Yes *(please give reason why)*☐ No ☐ Any other comments:  |
| Was the child managed at a principal treatment centre? | ☐ Yes☐ No *(please give reason)* |
| Was there a delay in referral to the paediatric or TYA principal treatment centre?  | ☐ Yes *(please give reason why)*☐ No ☐ Any other comments:  |
| Did the principal treatment centre accept the child rapidly following referral?  | ☐ Yes ☐ No *(please give reason why)*☐ Any other comments:  |
| Were there any logistical issues with transferring this child between the referrer and the principal treatment centre?  | ☐ Yes *(please specify)*☐ No ☐ Any other comments:  |
| Was the child treated in the right place for their condition?  | ☐ Yes ☐ No *(please give reason why)* |
| Was this child offered access to treatment through a clinical trial?  | ☐ Yes, offered trial at the treating hospital and  accepted☐ Yes, offered trial on the national trial portfolio at  another centre and accepted☐ Yes, offered trial at the treating hospital but  declined☐ Yes, offered trial on the national trial portfolio at  another centre but declined☐ No, no trial available at the treating hospital☐ No, no trial available on the national trial portfolio  at another centre☐ No *(please specify if reasons different from above)* |
| Did the child have access to appropriate psychological and/or psychiatric support?  | ☐ Offered and accepted ☐ Offered and declined ☐ Service not available ☐ No *(please specify if reasons different from above)* |
| Was a DS1500 (financial aid form) done for this child? | ☐ Yes☐ No |
| Did the family have support to access financial aid? | ☐ Yes *(please specify from whom)*☐ No |
| Do you think the death was a consequence of an effect of the treatment given? | ☐ No☐ Yes *(please specify cause)*☐ Surgery ☐ Radiotherapy ☐ Chemotherapy ☐ Other *(please specify)*  |
| If **yes**, was the death within 30 days of that treatment? | ☐ Yes☐ No |