Learning from Children's Deaths

A newsletter for professionals

July 2021, Volume 1, Issue 6

In this issue:

- Introducing Sarah Steel
- Bouncy Castles Advice
- CDOP notifications
- SUDIC
- NCMD annual report
- Save the Date
- Children with disabilities
- Fathers, partners & significant others
- Suicide
- Escalation of concerns
- Contact details
- Expected Deaths

Suffolk Child Death Review Team

The Suffolk Child Death Review Team went live on 1st September 2019.

Dr Sarah Steel - Designated Doctor for Child Death Suffolk

Cindie Dunkling - Designated Nurse for Safeguarding Children and Lead for Child Death

Jacky Wood – CDR Nurse

Bernie Spiller – CDR Nurse

Lucy Lavender - CDR Nurse

Team Contact Details

Team phone number: 01473 770089

Team pager: 07623 951892

Email: iesccg.suffolkcdr@nhs.net

Service available: 8am - 4pm, Monday - Friday (on call 4pm-8pm on weekdays)

Introducing Sarah Steel

Hi I am Sarah Steel and have been the Designated Dr for child death initially in Norfolk since 2018 and Suffolk since 2019.

I am a community paediatrician and became a consultant in 2000. I trained in Bristol and moved to the midlands then peak district and was lucky to spend time in Australia, New Zealand and Scotland before settling in Norfolk with a brief year in California around the time I took up my consultant post (extended maternity leave!).

I have spent many years in safeguarding roles, and it was as Designated Dr for Safeguarding that I was first involved in CDOP. I realised that we needed to develop the roles of the nurses who were providing a rapid response service but not able to offer ongoing support to families. The guidance also changed in 2018 and I took on the role of Designated Dr for CDR. I feel very honoured to work with all the dedicated staff across the many provider trusts, hospices and CCG, police, education, social care and the voluntary sector and see all the care they give to families. Everyone wants to do their best and everyone suffers when a child dies, not just the families. However, there is still work to do to reduce our mortality rate further in children.

Outside of work I enjoy walking, running and cycling and love eating and seeing friends. My garden is a bit haphazard, but I find it very relaxing.

Bouncy Castles/ Inflatables

While inflatable play equipment is normally a very safe and pleasurable way for children to exercise whilst having fun, poorly designed or badly worn equipment can increase the risk of injury to its users. Testing of inflatable play equipment is a mandatory requirement as outlined by The Provision and Use of Work Equipment Regulations 1998 (PUWER). PIPA is an inspection scheme set up by the inflatable play industry to ensure that children's inflatable play equipment conforms to recognised standards.

Only Inspectors operating under either PIPA or the Amusement Device Inspection Procedures Scheme (ADIPS) are recognised by the HSE (Health and safety Executive). There are a number of Inspectors operating nationally who are not registered with either scheme. While they may test inflatables to the recognised standard BS EN 14960, their credentials are not supported by an independent body. The HSE have indicated that they do not support individual Inspectors.

Each piece of conforming equipment supplied by a reputable manufacturer or importer is "tagged" with a unique number which is attached to the inflatable throughout its life. The tag number is logged on a central database where the results of its initial test and subsequent annual tests are recorded. In addition, a report is issued with each test. All users have access to the PIPA database via the Internet (www.pipa.org.uk) and can therefore check on the inspection status of any tagged equipment before using. If the equipment has not been checked by a PIPA approved inspector, the owner must be able to prove that the testing has been carried out by a competent person and should be able to show you the report.

Anecdotal evidence suggests that many professionals along with the general public are not aware that you can complete this simple safety check online before using inflatables. PIPA is hoping to be able to develop an app to make it easier for the people to check the safety of equipment before using but this is some time away from being developed. It the mean time please spread the word that anyone can check the safety certificate of inflatables by simply going on : PIPA Inflatable Play Inspection - Safe Bouncy Castles.

Regardless of COVID restrictions, any equipment in use should have had an inspection within the last 12 months. No extensions to certificates should have been made

CDOP Notifications

The statutory Child Death notification form is arguably the most important form in the whole Child Death Review (CDR) process. Not only does it notify the CDR Team/CDOP/ NCMD of the death of a child but, when completed well, it can also provide a comprehensive list of all those professionals who cared for the child during their life and immediately after their death. It is this list which enables the CDR Team to carry out the rest of the process. Without it, gathering information about the child is very challenging. By completing a notification form well, you will make an enormous difference to the process. Any professional can complete the form with details about the child, their family, and the death. It should be completed within 48 hours of the death to ensure the process is started.

NCMD Annual Report

The NCMD have just released their second annual report. You can read the full report here. There were almost 3500 children's deaths that the report has focused on to pull out themes and learning. A key finding was children dying in areas of deprivation in the country. The report gives an excellent oversight in to how deaths are reviewed in the country and the trends and themes that are seen. Professionals can look at how the NCMD take the information they are given, and what they do with it to promote learning and inform processes within child death.

Fathers, partners/ significant others

Through reviewing some recent cases, the CDR Team have seen that fathers or partners are often not included on the child's health records or in the giving of health and safety advice. In the majority of cases focus of children and family services are on the mother and child, excluding to some degree significant others in the family. With few exceptions, father's and partners roles within families are positive for the child's wellbeing and family functioning. Excluding them from the child's records, opportunities to receive health care advice and appointments disadvantages the child. Including fathers and partners in the work we do can help improve outcomes for children. In the few cases where a father or partner's behaviour may pose a risk to the child, professionals are hampered from making holistic assessments by the lack of information recorded or known about significant others in the family who may have cared for the child.

SUFFOLK CDR TEAM PRESENTS

LEARNING EVENT AROUND CHILD DEATH

11TH -15TH OCTOBER 2021

TOPICS TO INCLUDE SUICIDE, CHILDREN WITH DISABILITIES, SUDIC, TALKING ABOUT DEATH AND LOSS, NEONATAL DEATHS

VIRTUAL DAILY SESSIONS FROM 10AM – 11.30AM

WILL INCLUDE QUESTION AND ANSWER SESSIONS WITH GUEST SPEAKERS

INSTRUCTIONS TO FOLLOW PLEASE TELL YOUR PROFESSIONAL COLLEAGUES

SUDIC

Following the Sudden Unexpected Death of an Infant or Child the SUDIC protocol is followed. The protocol should be applied to all initially unexpected and/or unexplained deaths of Suffolk infants, children and adolescents up to their 18th birthday. This includes all sudden accidental deaths, road traffic collision deaths and where sudden, unexpected collapse is expected to lead to death.

Professionals from a number of different agencies and disciplines will become involved following an unexpected death in infancy or childhood to try to establish the cause of the death and support the family. This protocol is intended to provide guidance to the professionals confronted with these tragic events. It is acknowledged that each death has unique circumstances and each professional has their own experience and expertise to draw on in their handling of individual cases. There are, however, common aspects to the management of unexpected death in infancy or childhood and it is important to achieve good practice and a consistent approach.

When dealing with an unexpected death in infancy or childhood, all agencies need to follow five key principles:

- Sensitive, open minded, balanced approach.
- Inter-agency Response.
- Sharing of Information.
- Appropriate response to the particular circumstances.
- Preservation of Evidence.

https://suffolksp.org.uk/assets/2020-11-SUDIC-Protocol-002.pdf

Children with disabilities – are they invisible??

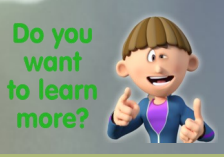
In the last two years the CDR team have supported families of children with disabilities who have sadly died, some expectedly and some unexpectedly despite their conditions. In looking at their deaths some of the learning that has come out has been that these families and children can sometimes become invisible to professionals. Families often provide all of the care for these children and when seen by professionals, often parents are relied upon for information and care more than they should be. The child themselves often cannot express their wishes or how they are feeling when they feel unwell or unhappy. Professionals should be conscious of what they can't see or what they are not being told when the child is in front of them. What parents do or say when they are with or seen by professionals can be very different to what happens in the home environment, and we should always be mindful of red flags we may see or signs that all is not as it seems. These children are extremely vulnerable, and they should be treated as such when seen.

https://learning.nspcc.org.uk/media/1200/safeguarding-disabled-children-england.pdf

The CDR team are keen to educate professionals in Suffolk about the Child Death Review Process, the Child Death Overview Panel and what to do when a child dies. We have started to roll out teaching packages so that staff will know about our role and what we do, and also to discuss the learning which is coming from children's deaths. If you would like us to be part of your teaching session or study day, please contact us at :

iesccg.suffolkcdr@nhs.net

These sessions are a great opportunity for us to meet and talk to staff



Escalation of concerns

3 child deaths that have resulted in the Suffolk Safeguarding Partnership (SSP) carrying out Child Safeguarding Practice Reviews (previously Serious Case Reviews). Each case review has highlighted the need to escalate concerns through your organisations safeguarding teams as they arise. Multi-agency working to keep children safe is often complex and emotionally charged which can lead to professional disagreements and conflict. The SSP escalation policy is available for all professionals working with children and families as a guide of when and how to escalate concerns and work through any professional disagreements. This policy sets out clear routes to escalate professional concerns where there are fears that a difference of opinion may be getting in the way of keeping a vulnerable person safe.

https://suffolksp.org.uk/assets/Working-with-Children-Adults/Policies-CYP/Escalation-Policy/2020-02-01-SSP-Escalation-Policy-v5.pdf

Suicide

Suffolk's Suicide Prevention Strategy: Suffolk County Council is leading a new, joint plan bringing together several organisations, all working towards reducing suicide as a priority for health and wellbeing in Suffolk. While no single organisation is responsible for preventing suicide, a range of professionals from the voluntary and charity sector, clinical commissioning groups, local councils, police, Health Watch Suffolk, coroner's office and mental health services all play a crucial role. You can find out more on Suffolk Suicide Prevention along with suicide support services here:

https://www.healthysuffolk.org.uk/projects/suffolk-lives-matter#services

NEW – Bereaved by Suicide Service for Child and Adult suicides. Bereaved by Suicide Service (BBS) run by Victim Support aims to ease the distress and improve the wellbeing of those in Suffolk and Colchester and Tendring who have been bereaved by suicide. The service provides emotional support, practical help and signposting to other organisations. This is an all-age service to support all residents in Suffolk and North East Essex, with the exception of the Waveney area of Suffolk. Trained staff will be equipped to signpost to support for Waveney residents and those who live outside of North East Essex. The service is free and confidential.

Email: BBS.support@victimsupport.org.uk
The national Support line service is available 24/7 on: 08 08 16 89 11

The stay alive APP is a pocket suicide prevention resource for the UK, packed full of useful information to help people stay safe. A independent evaluation report (PDF) in 2020 showed the app helped 76% of at-risk users to stay safe from suicide. You can use it if you are having thoughts of suicide or if you are concerned about someone else who may be considering suicide. In addition to the resources, the app includes a safety plan, customisable reasons for living, and a life box where you can store photos that are important to you. Clink on the link below for further information and to see how professionals across health, social care, and police in Sussex have been promoting the app with patients, service users and staff Stay Alive App ~ Grassroots Suicide Prevention (prevent-suicide.org.uk)

National Child Mortality Database (NCMD) carried out a real time study into suicides during the covid 19 pandemic. The full report can be found here: https://www.ncmd.info/wp-content/uploads/2020/07/REF253-2020-NCMD-Summary-Report-on-Child-Suicide-July-2020.pdf

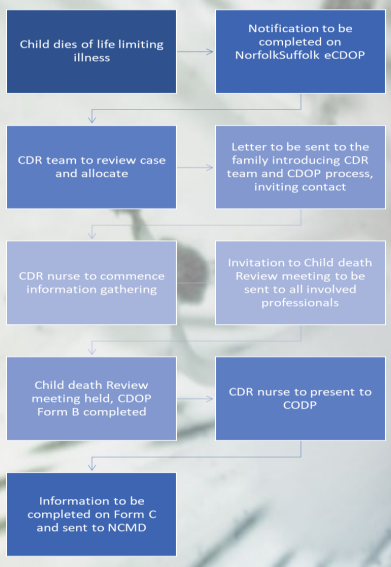
Downloadable resources for suicide prevention:-

Suicide prevention ~ Download Resources ~ Grassroots (prevent-suicide.org.uk)

Expected Death Pathway & Process

The CDR team has been working on the process that is followed when there is an expected child death. As professionals know we have a good process in place for unexpected deaths but lately we have noticed that our process for expected deaths could be a lot better and more responsive. Following some feedback from some of our families of expected deaths, we are now responding differently and trying to include as many professionals as possible in de briefs and meetings. A member of the team will now contact the family in the first week following the death and explain our support and the Child Death Overview process. If the family would like a visit or further support, we will be available. We will also be organising a debrief for professionals and then the further CDRM meetings to gather information for the child death process. Please attend if you are invited to these meetings as you may have information about the child that we need.

We have also started meeting with professionals to discuss children who have life limiting conditions or illnesses so that we can be involved with these families and know about these cases as early as possible. It is a good opportunity to start gathering information that will help us understand the circumstances of the illness and what care and support the child and their family is already receiving.



If you would like to receive this newsletter, please click here to sign up.

Produced by the Child Death Review Team, Suffolk, NHS Clinical Commissioning Group, Endeavour House, Russell Road, Ipswich, IP1 2BX