Learning from Children's Deaths

A newsletter for professionals

June 2023, Issue 12

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CONTACT DETAILS

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Suffolk Child Death Review Team

Dr Sarah Steel - Designated Doctor for Child Death Suffolk

Cindie Dunkling - Designated Nurse for Safeguarding Children

Jacky Wood – Lead CDR Nurse

Bernie Spiller – CDR Nurse

Natalie Okeh - CDR Nurse

Louise Skinner - Admin

Team Contact Details

Team phone number:

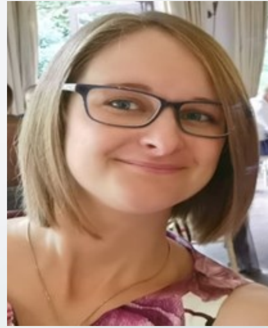
01473 770089

Email: suffolk.cdr@snee.nhs.uk

Service available:

8am - 4pm, Monday - Friday

Introducing Louise Skinner



Hi I am Louise Skinner and I joined the CDR Team at the beginning of May this year as their Administrator. I have always worked in an Administration role, from working at the Suffolk County Council, to CYP Social Care Team, to Education.

I have also worked as part of an Activity Group in the Social Care Team where I took vulnerable children out to partake in activities at the weekends.

As well as working in the CDR Team, I am a Matron at a private school looking after boarders at the weekend so working with or work that involves children is my passion. I enjoy working in whatever small way I can to protect and make the future of our children a little brighter.

In my short time of working in the CDR team, I have loved being part of the team and I feel like I am where I am meant to be. I am truly honoured to support and be part of such an amazing team.

Suffolk Child Death Review Team : Learning from Child Death

Free Annual Study Day 2023

Wednesday October 18th

Open to all professionals interested in Child Death processes and policies.

More details to follow- lunch provided

Day will include a detailed look at various cases nurses have worked on from different points of view, including the parents perspective

Guest speakers will also be presenting.

TICKETS BELOW :

https://www.eventbrite.com/e/learning-from-child-death-in-suffolk-tickets-640602779157

Please note: The study day run by the CDR team is different each year and this year will focus on a lot of our cases and the learning extracted from those cases. Our agenda this year has been put together based on feedback from last year's study day. People are very interested on the role of the CDR Nurses and the process around Child Death in Suffolk and that will be the main focus of this year's study day.

This study day is open to all professionals in Suffolk so please pass the details to members of your teams and organisations. We would love to see as many of you as possible attend. If you have any questions about the study day or problems obtaining tickets please email suffolk.cdr@snee.nhs.uk and a member of our team will be more than happy to help.

Drug awareness for upcoming Festival Season

At this time of the year we see many festivals happening around the country and many professionals see a rise in alcohol and drug consumption by young people and young adults.

There are a number of courses being offered to professionals to increase awareness around this subject including

- Practical Harm Reduction
- Drug Awareness
- Alcohol—The Constant Pandemic
- From Party to Pharmacy - awareness round party drugs
- Chemsex Awareness

To book a place on any of the above or below training please contact:

Katy Howgego, Senior Administrator, Essex Partnership University NHS Foundation Trust (EPUT) Email: katy.howgego@nhs.net Telephone: 07583 122419

There are also a variety of online workshops that can be booked onto :

Practical Harm Reduction

Heroin, Methadone & More

Cannabis – From "Skunk" to Medicine

Heroin, Methadone & More

Cannabis – From "Skunk" to Medicine

Alcohol – The Constant Pandemic

Heroin, Methadone & More

Drug Awareness

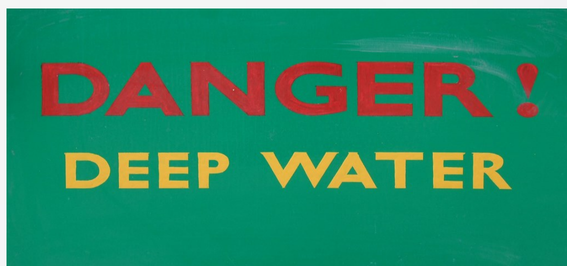
Practical Harm Reduction

From Party to Pharmacy – E, K and Pharmaceuticals

Cannabis – From "Skunk" to Medicine

Alcohol – The Constant Pandemic

WATER SAFETY



The National Child Mortality Database (NCMD) and Child Death Review teams around the country have been involved in some recent cases where families have lost a child through drowning accidents. This has highlighted the need for more learning and safety around swimming pools, ponds, paddling pools, rivers and going to the beach. Approximately 700 people die each year in the UK in drowning accidents. On average 5 under 6's die every year in garden ponds.

Children should never go near water alone. They need adults to be alert to cold water and the sea's unpredictable waves and rip currents. Especially as in recent summers the RNLI sated that there were fewer lifeguard patrols on hand to ensure safety in the water. In particular, they advise that:

- when near water, children should be watched by adults at all times
- inflatables should NOT be used
- children should float on their backs if they are struggling in the water

families should alert a lifeguard if nearby and leave difficult rescues to the lifesavers (call 999 and ask for the Coastguard). For more information, go to: https://rnli.org/safety/beach-safety and https://www.rospa.com/Leisure-Safety/Water/Advice/Children-Young-People/

Ponds, slurry pits and standing water

The Royal Society for the Prevention of Accidents (RoSPA) estimates that garden ponds are involved in more than half of all toddler drownings. For families with children, they recommend that ponds are:

- covered by a strong metal grille (NOT chicken wire)
- surrounded by a fence at least 1.1m high, or filled in, particularly when children are young.

For more information, go to: https://www.rospa.com/Leisure-Safety/Water/Advice/Pond-Garden-Water/

CHANGE OF CONTACT DETIALS FOR THE CDR TEAM

Unfortunately, our pagers are being removed from service and are no longer in use. Instead of paging our team can you please call our team landline number and leave a message if we do not answer. We have implemented processes to ensure urgent calls are returned ASAP, but we will be monitoring this as a team.

Our contact details on the SUDIC policy and the Managing Child Deaths Policy have been amended and are attached above for you to update within your organisation. **Our NHS accounts are also due to be discontinued** so please see our new contact details below :

******NEW CHILD DEATH REVIEW CONTACT DETAILS*******

Team Number: 01473 770089

Team email: suffolk.cdr@snee.nhs.uk

GOOD PRACTICE RECOGNISED

As well as pulling out learning to improve practice we also find examples of excellent practice when reviewing Child Deaths. Parents generally value and are extremely grateful for the care their Child has received in all hospital trusts.

Parents that have been able to access the Children's Hospice are extremely grateful they are able to spend quality time with their child and make lasting memories.

One example we would like to share is that of excellent multidisciplinary working in collaboration with the family.
After the sad death of a 5month old the hospital advised a post-mortem to ascertain the exact cause of death of this Child and that the hospital could not issue a MCCD, however the family were very adamant they didn't want a PM to happen. The parents expressed their thoughts that their Child was a very poorly boy and had been through enough and although his death happened quicker than they thought they knew it was likely to happen in his childhood.

The CDR team nurses showed excellent advocate working and together with the Paediatrician, coroner and family working together a decision was made for the coroner to issue an uncertified cause of death - a report was provided by the paediatrician with a cause of death on the balance of probability. Listening to families, listening to parents, being their advocate in distressing times, ensuring they can make informed decisions and supporting their choices is a big part of our role as a CDR nurse. The CDR nurses, Paediatrician and Coroner were able to successfully work together to bring the best out come for this family. An example of excellent multidisciplinary working.

CHICKENPOX

In the last year we have seen 2 deaths relating to chicken pox within the county. Both children were relatively fit and well prior to getting chicken pox and sadly died as a result of this infection. Symptoms include an itchy spotty rash, temperature, aches and pains, a loss of appetite and generally feeling unwell. It is easy to catch chickenpox and children can spread it 2 days before any spots are seen and up to 5 days from when the spots appear.

During this time, advise a person with chickenpox to avoid contact with:

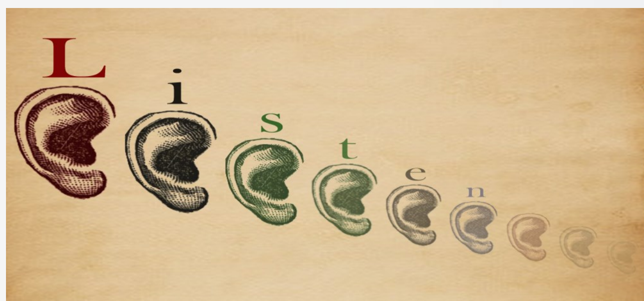
- **People who are immunocompromised (for example those receiving cancer treatment or high doses of oral steroids, or those with conditions that reduce immunity).**
- **Pregnant women.**
- **Infants aged 4 weeks or less.**

Advise that children with chickenpox should be kept away from school or nursery until all the vesicles have crusted over.

You can get the chickenpox vaccine on the NHS if there's a risk of harming someone with a weakened immune system if you spread the virus to them.

For example, a child can be vaccinated if 1 of their parents is having chemotherapy.

Really Listening to Parents



A number of our cases recently have shown the sadness, anger and despair from parents when they have felt they haven't been listened to by multiple medical professionals. Their pleas for help being dismissed or details of their sick child being ignored or deemed insignificant. And in one case a parent was made to feel they were over exaggerating and that the symptoms were behavioural.

Let's remember these words from the General Medical Council:
'Good communication with parents is essential. Parents generally want what is best for their children and are experts in identifying when their child's behaviour is not normal for them and may be due to ill health. You should acknowledge parents' understanding of their children's health, particularly where a child's age or disability makes it difficult to communicate with them. (GMC 2023)'.

And those of Dr Mike Durkin, the NHS national director of patient safety(2016) . Too often parents worry "about 'time-wasting' with any repeated concerns" or that they won't be listened to, but "it is imperative that parents feel welcome and encouraged to speak up". One child saw 6 different primary care professionals in 16 days. None of which the mother felt she was listened to by.

One case showed parents feeling let down and guilty that they didn't shout louder, didn't demand for more. The child was discharged home unable to walk, not eating and drinking, not being able to swallow and sadly died the following day.

One Mother felt her child was seriously ill but he wasn't showing the "normal" sepsis presentation. Despite visiting the GP surgery 3 times in 5 days and again being seen by 3 different professionals, the parents felt they too weren't being listened to, and when he was taken to A+E 2 days later, it was too late.

As a reminder to all, children can present in so many different ways and can deteriorate quickly. If parents feel their child is seriously ill, if they keep presenting to the GP, If they are overly worried, please listen to them and act on what you hear. Parents know their child the best. It may just save a life.

The Safe System Framework is the first NHS-wide resource of its kind aimed at reducing potentially fatal deterioration in young patients' health. Launched by NHS Improvement and the Royal College of Paediatrics and Child Health, it stresses the need to work closely with children's parents and carers.(2016).

Please find more information here :

https://cdn.ps.emap.com/wp-content/uploads/sites/3/2016/07/A-safe-system-for-children-at-risk-of-deterioration-ver-4h.pdf

Produced by the Suffolk Child Death Review Team,
Suffolk and North East Essex NHS,
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Ipswich, IP1 2BX

Health Information Exchange (HIE)

The HIE enables a real-time view of health information between Health Care Providers who are using differing IT systems, providing a more seamless approach for direct patient care. The data sharing agreement for this is in place, under the My Care Record IG framework. A staff member now has the potential to view a snapshot of health and social care information from within the person or patient's record in a single view, without having to log into different systems. This information is largely real-time and read-only.

As of January 2023:

-Over 2,000,000 records are available from across Suffolk, Norfolk, Essex, Cambridgeshire and Hertfordshire.

-GP practice and Community Units across Suffolk, Norfolk, Essex & Hertfordshire

-CUH / Addenbrookes data – Note: Encounters, Results,

Documentation & Procedures are shown for the previous 90 days only

-Inpatient-stay Discharge Summaries only, from other regional Acute Trusts

-St Elizabeth, St Nicholas & St Helena Hospice records

-Essex County Council Social Care records *More data coming soon*

-Suffolk County Council Social Care records *More data coming soon*

-Essex Partnership University NHS Foundation Trust Mental Health records *More data coming soon*

-Norfolk and Suffolk Foundation Trust Mental Health records (including Wedgewood) *More data coming soon*

-NHS Norfolk & Waveney GP's *Coming soon*

-East Coast Community Healthcare CIC (ECCH) *New*

-North East Essex Virtual Wards *New*

-Suffolk Virtual Wards *New*

-Herts and West Essex Health Information Exchange *New*

Teaching

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 are hoping to continue to be part of organised study days in trusts and organisations in 2023/2024, 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 :

Do you want to learn more?

suffolk.cdr@snee.nhs.uk

These sessions are a great opportunity for us to talk to staff about particular cases and families which they may have had involvement with.