Learning from Children's Deaths

A newsletter for professionals

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Suffolk Child Death Review Team

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

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Introducing Cindie Dunkling

Hello, I'm Cindie, Designated Nurse for Safeguarding Children and the lead for the CDR Team. I trained in Suffolk as a paediatric nurse, based at Ipswich Hospital and then worked at EACH children's hospice before training as a health visitor in 2004. For the last 15 years I have worked in the area of safeguarding children in Suffolk and became Designated Nurse for Safeguarding Children in 2013. Recognising a gap in Suffolk for families experiencing the loss of a child and the need to learn from these tragic events I put together the Child Death Review Team. I am very proud of my team and what they have achieved over the 18 months they have been in post. I am looking forward to seeing the team evolve further over the coming years.

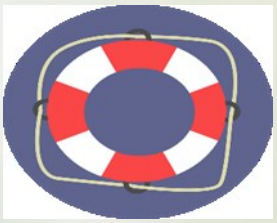
Home Safety Alert

Water

Following Child Death Overview Panel meeting in January 2021, we discussed a case where a toddler drowned after falling into the family swimming pool. Earlier in 2020, we also lost a child who drowned in a pond. This prompted learning and professional curiosity regarding water safety in family homes. Home safety is discussed with families, but the specific questions surrounding water safety, water hazards and water risks when out and about are not always documented or discussed. We know that most child deaths occur when there is a slight change in the normal routine and during the pandemic there are changes in the way we socialise and spend time in our homes. Swimming pools and hot tubs are becoming increasingly popular, especially considering the lack of family holidays abroad.

CDOP would like to encourage all professionals to be curious around what water hazards there may be in family homes. The UK does not have any legislation with regards to swimming pool security unlike France and other countries. Professionals are asked to be vigilant and document any hazards which may be present, as well as giving out clear water safety guidance.

For more information click here.



Safety Equipment

Whilst there are multiple devices to ensure family homes are safe, this should not be a substitute for parental supervision. Stair gates are frequently used safety devices to prevent children from accessing possible hazards. A standard stair gate is 75 cm high and the average height of a 2-year-old girl is 85 cm. In Suffolk, we have had 2 deaths associated with the use of stair gates. Children develop differently and due to their curiosity, ability, problem solving and developing gross motor skills, what they could not do one minute can rapidly change and they can become curious and get into difficulty very quickly. Children can climb stair gates which can then cause them to be at greater risk of harm than if a stairgate had not been present. Stair gates should also be used singularly, and two stair gates should not be used to extend the height of a standard stairgate. A recent case saw a 2-year-old die from an accident where 2 stair gates had been used one on top of the other. There has been a further similar case in Norfolk. We urge professionals to explore the use of safety equipment and promote parental supervision as all times. Alerts have been put out regarding the correct use of stair gates by public health and the 0-19 service in Suffolk. If you are a professional visiting homes with small children please consider the correct use of safety equipment if it is being used in the home.

This Photo by Unknown

The Suffolk Coroner's Service

Coroners are:

- judicial office holders
- independent and appointed directly by the Crown
- responsible for investigating deaths in Suffolk to find out how, when and where they occurred
- qualified with substantial experience as a lawyer or doctor (or sometimes both)

The Coroner will investigate a death if:

- it was violent, unnatural or suspicious
- the cause of death is unknown
- the person died in prison, police custody or any type of state detention

Investigating a death may be as simple as consulting with the doctor who last treated the person who has died, or a post-mortem examination may be needed.

In some cases, an inquest may be opened, which is a judicial inquiry into the death. An inquest takes place in a Coroner's Court.

The Coroner has a team of officers who liaise on his behalf with bereaved relatives, police, doctors, mortuary staff, hospital bereavement staff and funeral directors.

Coroner's Officers are the people you will speak to when you get in touch with the office.

If an inquest is opened, one particular officer will take responsibility for the case. They will then be the ongoing point of contact.

An inquest is a formal court hearing, open to members of the public and the media.

If appropriate, witnesses will be called, and in some cases a jury will be appointed.

The coroner will hold an inquest if:

- the post-mortem does not reveal the cause of death
- the death was unnatural and the result of an accident
- where the deceased was in a state of detention
- the coroner believes there is a good reason to continue investigations

The Coroner, or in some cases the jury, will come to a conclusion and formally state who died, where, when and how it happened.

A Coroner cannot apportion blame but where an investigation gives rise to concern that future deaths will occur, and the investigating coroner is of the opinion that action should be taken to reduce the risk of death, the coroner must make a report to the person that s/he believes may have the power to take such action. Prevention of Future Death Reports are vitally important if society is to learn from deaths. Coroners have a duty to decide how somebody came by their death. They also have a statutory duty (rather than simply a power), where appropriate, to report about deaths with a view to preventing future deaths.

You **do not** need to attend a coroner's inquest, unless you are called to be a witness, but in some circumstances documentary evidence can be accepted instead of attendance in court.

Coroners courts are courts of law and reporting of inquests is permitted by law. This means that press can attend the hearing and report accurately and fairly on any details given in open court. Press are regulated and guidelines state that reporting on inquests must be done with sensitivity.

Organ Donation - Children

Organ donation is not always considered or thought of when a child dies unexpectedly. It is especially significant if a child or baby passes away in an intensive care unit. One of our recent cases parents spent time with counsellors to consider organ donation but unfortunately no match was found for what their daughter could donate. We must also remember that discussions and time spent on organ donation can detract from time that parents could be spending with their child. There is no way of knowing that any conversations will lead to a match and a chance that some part of the tragedy will have a positive impact for another family. Not all professionals are comfortable mentioning organ donation at such a devastating time for families, this is especially true in neonatal intensive care.

Awareness of Organ donation in Suffolk has been added to the CDOP action plan and has also been raised at a recent neonatal Operational Delivery Network meeting. Norfolk and Norwich University hospital have shared some great practice with us that they have been doing to promote awareness of organ donation amongst staff and we would love to hear what other areas have been doing too, so please do make contact to share what your area has been doing. As of 18/2/21 there are 199 children waiting on the organ donation lists in the UK.

The UK Paediatric and Neonatal Deceased Donation Strategic plan can be seen here.

Congratulations!!!!

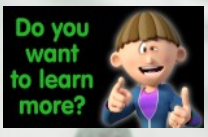
Huge congratulations to our colleagues in Norfolk who have just commissioned and employed their own Child Death Review team to work with professionals and support families when a child dies in Norfolk. The team will consist of three nurses and will cover Norfolk and cases in Waveney. The designate doctor for Child Death for Norfolk and Suffolk will continue to be Dr. Sarah Steel who has played a big part in obtaining funding for the new team. This means that there are CDR teams in Essex, Suffolk and Norfolk which is amazing for families and professionals in East Anglia. We look forward to working closely with our new colleagues.

FROM THE CDR TEAM

Perinatal Mortality Review Tool (PMRT)

The national perinatal mortality review tool was launched in January 2018. It was designed to support local perinatal mortality review groups to conduct systematic, standardised perinatal reviews of all stillbirths and neonatal deaths of babies born at 22+0 week onwards and babies who die in the post-neonatal period having received neonatal care. The PMRT has been designed with user and parent involvement and includes the capacity to incorporate the parents' perspectives of their care to ensure these are considered in the review process. The CDR team has been to several PMRT meetings in Cambridge, Norwich, Ipswich and now London (thanks to teams) which consist of a group of professionals meeting to discuss the mother's pregnancy and babies' birth. Each meeting is run in a different way although these meetings are becoming more standardised across the trusts we visit. The child death strategy guidance states in all cases, the review meeting (PMRT/ mortality and morbidity) should generate an Analysis Form, which should be sent to the local CDOP. By the CDR nurse being involved in these meetings we can complete these forms and then present to CDOP meeting these statutory requirements.

If you would like to read more about the statutory requirement for the child death review of neonatal deaths then please search PMRT in the national policy please click here.



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 for 2021, 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 talk to staff about particular cases and families which they may have had involvement in.

Please see the **Suffolk Safeguarding Partnership** website for more details around CDOP, including protocols around child death.

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

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