Learning from Children's Deaths

A newsletter for professionals

April 2022, Issue 10

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Introducing Anthony Douglas

Anthony Douglas was Chief Executive of Cafcass from 2004-19 and now has a small consultancy business working in the UK and internationally, specialising in system leadership and rapid improvement. He took Cafcass from an 'inadequate' to an 'outstanding' Ofsted rating and from working with 60,000 children a year in 2008 to 140,000 in 2019. Anthony was an economist and a journalist prior to becoming a social worker and has written 4 books on UK social care and is now writing a fifth book on the contribution of the helping services to a civilised society. He is a Visiting Professor at UEA and was given the 'outstanding contribution to social work' award at the Social Worker of the Year Awards in November 2018. His portfolio now includes overseeing children's services for the Welsh Government: acting as a Senior Intervenor for NHS England into systems which have inter-agency difficulties; and contracts overseas to improve services to people at risk. His main focus now is being the Independent Chair of the Suffolk Safeguarding Partnership as he lives in Suffolk and wants to support improvement to public services across Suffolk. As part of this work, he chairs the Suffolk Child Death Review Panel, a crucial review mechanism for improving all of those local services which play a part in keeping Suffolk children alive.

" Suffolk has an outstanding child death review (CDR) process. Each tragic death is scrutinised to understand what happened, to learn the lessons and to apply them in order to reduce the risk of future deaths. We are fortunate in Suffolk to have an outstanding child death review team whose nurse practitioners support grieving families and take time to understand the lessons from each death in depth and in detail and to take the learning forward into all of those arenas, services, interventions and procedures which need to change. I have the highest regard for the work of the team and the work of the inter-disciplinary specialists involved in the CDR process. I am privileged to be supporting them and to try to add value to this important statutory work"

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

Maddison Bultitude—CDR Team Administrator

Team Contact Details

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

Think … Bereaved Parents

The child death review role supports and signposts families for as long as they feel they need the support, this can be for a short time or until well after an inquest. Families also have open access to the service following the loss of their child. As the family's key worker, we are often up to date with the family situation, how they are coping, bereavement support they are accessing and the support networks available.

Where there are families with siblings or a mother who becomes pregnant again there may be times where is it essential to share information and communicate. In our experience families really do not like to revisit the trauma of losing a child and part of our role is to prevent the need for this.

We are available for joint visits to introduce new professionals and we can provide advice on how to support bereaved parents. In addition to this we can provide supervision and debriefs to professionals who worked with the child prior to death, giving them an update on the family.

Prior to sharing information, we always seek consent from our families.

Please do not hesitate to contact the team on 01473 770089 or email on *iesccg.suffolkcdr@nhs.net*

Significant others

Sadly we are still reviewing cases following the death of a baby or child where the details of the father, partner or significant others in the household is not recorded on the health records. This has raised some safeguarding concerns as in some circumstances a male in the household has been assumed to be the father and to have Parental Responsibly (PR) when that is not the case.

The Child Safeguarding Practice Review Panel published **The Myth of Invisible Men** in 2021 which looked at non accidental injuries in under 1's. The report suggests, despite evidence suggesting some men are very dangerous, service design and practice tends to render fathers invisible and generally 'out of sight'.

The report also takes stock of how well safeguarding and other services engage with men. It sets out systemic weaknesses in the way that universal and specialist services operate. Too often, even if unwittingly, they enable men to be absent. Importantly, services do not maximise opportunities to identify and respond to the vulnerabilities and risks that some men can present.

SIDS—Refresh

We have been looking back at our last 7 SIDS cases recently comparing them and pulling out some contrasts. Below are some risk factors we have seen that we should all consider when talking about safe sleeping for babies.

- **Tobacco – pregnancy and environmental exposure**
- **Alcohol and drugs – during pregnancy and when co-sleeping**
- **Poor post-natal care – late booking and poor ante-natal attendance**
- **Maternal obesity**
- **Social-economic deprivation**
- **Low income family**
- **Parental Mental health**
- **Criminal history**
- **Adverse childhood experiences**
- **Previous safeguarding concerns, cumulative neglect**
- **Poor engagement/late booker**
- **Low birth weight (under 2,500g) and preterm birth (less than 37 weeks' gestation)**
- **Unsafe sleep position (prone or side), Unsafe sleep environment:**
- **– co-sleeping in the presence of other risks (including bed sharing**
- **– overwrapping (head covered, use of pillows or duvets)**
- **– soft sleep surfaces (soft or second-hand mattress)**
- **Altered sleeping arrangement**

National Child Mortality Database

The NCMD programme began in 2018, and 2021 was the first year that sufficient data was shared in order to improve and save children's lives. NCMD published analysis of the data that is collected, in five academic papers, two data releases, two thematic reports (on the impact of social deprivation and suicide on child mortality) and a briefing during the year. Collectively, those publications were seen by 32,000 people on the NCMD website – and as many as 27.5m people saw findings shared in the press and other websites.

The findings were used by the NHS and the Joint Committee on Vaccination and Immunisation (JCVI), among others, to inform policy decisions on the most pressing issues causing deaths among children and young people. The findings on Covid-19 and its impacts on children and young people, derived from real-time data on deaths among children testing positive for the virus, were particularly important as the pandemic continued to develop.

Transitioning from Children's to Adult Services

From the pond to the sea, this is sometimes what is used to describe going from children's services/ paediatrics to adult care and yet we are still seeing this happen just weeks if not days before a young person's 18th birthday rather than in a planned transition starting at 14. For young people and their families this transition period is a critical time in their lives which can sometimes be frightening and difficult to navigate. We have seen some examples of good practice where good timely, planning has taken place but equally we have all too often also seen evidence in delays of urgent care, fragmented services and confusing systems. In 2014 the CQC reviewed children's transition to adult health services, From the Pond to the Sea, reported every young person with complex physical health needs, from age 14 should have:

- A key accountable individual responsible for supporting their move to adult health services.
- A documented transition plan that includes their health needs.
- A communication or 'health passport' to ensure relevant professionals have access to essential information about the young person.
- Health services provided in an appropriate environment that takes account of their needs without gaps in provision between children's and adult services.
- Training and advice to prepare them and their parents for the transition to adult care, including consent and advocacy.
- Respite and short break facilities available to meet their needs and those of their families.
- Children's services provided until adult services take over.
- An effectively completed assessment of their carers' needs
- Adequate access to independent advocates for young people.

We still have a way to go to get these vital things in place consistently for all our children with complex needs in Suffolk.

Safety Notice!!

Our Child Death Overview Panel (CDOP) has been alerted to child deaths in other areas which were caused by falling fireguards, as well as children sustaining life changing injuries. We are asking all practitioners working with parents/ carers of young children to increase awareness of the risks of unsecured furniture, televisions, and fire surround so that we can help prevent these accidents from happening. More information and resources can be found here

Knotted/braided cot bumpers – Remember a clear cot is a safer cot

There is an increased trend in Suffolk of knotted/braided cot bumpers available for sale on several online sites (including social media sites). Although these can look pretty, they can pose a danger, putting babies at risk. Suffolk Trading Standards took a sample of braided cot bumper from one of their local importers, which failed to meet the relevant safety standards. The bumper could be used like a step and therefore posed a potential fall hazard. It was possible to separate the braids with minimal force producing gaps into which a young child could fit their head. The product could not attach to the side of a cot and could therefore be drawn in from the sides, posing a potential overheating and suffocation hazard.

Keep up to date with Suffolk Trading Standards by following them on Facebook, Twitter and Instagram or subscribe to their YouTube channel for their latest videos.

Remember to continue to share information on safer sleep for babies and to make every contact count.

Safer Sleep - Healthy Suffolk

How to reduce the risk of SIDS for your baby - The Lull-

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 2022, 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 with.

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

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

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