Learning from Children's Deaths

A newsletter for professionals **March 2023, Issue 12**

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Please see the NCMD website for more information on national learning from Child Death Reviews and access to free webinars and events

NCMD | The National Child Mortality Database

Suffolk Child Death Review Team

Dr Sarah Steel - Designated Doctor for Child Death Suffolk

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Team Contact Details

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Service available: 8am - 4pm, Monday - Friday

Introducing Katherine Piccinelli

Hi!

I would like to introduce myself as the (relatively) new Named Doctor for Child Death at West Suffolk Hospital.

I have been a Consultant Paediatrician here since 2009, with a particular interest in Oncology and Palliative Care.

Since 2021 I have also worked as a Medical Examiner.

Becoming Named Doctor seems to fits well within and complement my other roles.

As health professionals we have a duty to the children and young people that have died, and their bereaved families to, with compassion and respect, learn as much as we can to prevent recurrence if at all possible.

Young Carers

Please remember that if you identify a young carer to refer them Suffolk Family Carers so that they can get the support they need. Don't presume someone else has referred – check. The Children and Families Act 2014 states that young carers have a legal right to a Young Carers Needs Assessment. Suffolk family young carers currently complete the Assessment with the child or young person on behalf of Suffolk County Council.

Suffolk Family Carers welcome registrations for young people aged 5 years and upwards, who are doing more than would usually be expected of a person their age due to the long term condition of a family member. Remember this is not just physical help but also children having to give emotional guidance and support.

You can find out more about young carers here.

Suffolk Young Carers

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.

Please pass this along to all colleagues who may be interested

Child Deaths—A busy start

The CDR team have had a busy start to the year seeing a sharp increase in cases for the first 3 months. There have been 13 child deaths in Suffolk since January 1st 2023. These have a been a mixture of different scenarios and include children of all different ages. Cases include neonatal, expected deaths and also SUDIC's. There is no apparent reason for this busy period and the CDR team continue to support families and start the child death review process for each case. Many thanks to our colleagues that we work closely with for supporting us and helping during this busy time.

Team Update From Jacky Wood—Lead CDR Nurse !

Cindie Dunkling is stepping back into her designate role full time, and I have been successful in becoming the lead CDR nurse and will be managing the day to day running of the CDR team. I am excited to be taking on this role with the support of Bernie and Natalie. I will be increasing my hours to 4 days and Bernie and Natalie will remain working 3 days each. Sadly, Maddie our administrator left our team at the beginning of March to explore an opportunity within the education sector, she will be greatly missed, please do bear with us whilst we recruit into her post.

Please feel free to reach out to me anytime , I can be contacted on Jacquelyn.wood@nhs.net or 01473 770089/07908457031

How well do we Listen to Parents ?

A few of our recent cases have highlighted that parents feel they are not always listened to when their child is critically sick, and they are very worried about them. Ultimately these children have died from an acute illness and in supporting parents we are getting feedback that professionals did not always take into account how the parents felt, how worried they were or how they perceived the situation as it was happening. This has left parents feeling angry and guilty over not trying harder for their sick children when they were having treatment or been seen by professionals. We are all guilty of being busy and not always taking the time to sit with parents and really hear what they are saying and feeling about situations. Listening is one of the keys to effective communication. When we listen well, **we get more information about children and their families**. We also get the full benefit of parents' and carers' in-depth knowledge of their children. And we show parents and carers that we value their experience, ideas and opinions and take their concerns seriously. In every interaction with parents and carers, one of our goals should be to strengthen a partnership with them. We will be more likely to achieve this goal if we consistently **listen and speak to parents in a clear and considerate way**.

Domestic Abuse

One in 20 adults experienced domestic abuse in the year ending March 2022 and record numbers of children are affected by this horrific crime. **

With the **Victims' Bill** progressing through Parliament, in February, the **Government** set out new measures to address d**omestic violence**. The announcement included tougher management of **dangerous offenders**, **identifying perpetrators** before conviction, piloting civil orders, and categorising **violence against women and girls** as a national threat. **Clare's Law** has been strengthened. New **funding** is promised, from April, for perpetrator interventions. This raft of initiatives and policy, follows the **Domestic Abuse Act;** and 2022's statutory guidance, recognising children as victims of domestic abuse in their own right.

Domestic abuse is a crisis that affects us all, and it has devastating impacts; a woman is killed by her male partner or former partner every four days in the UK England and Wales. This must change.

A recent case in Suffolk highlights that there is still work to be done in awareness and training of domestic abuse. The Case highlighted the following:

- *CIN meetings need to be held routinely.*
- *Social workers need to discuss cases with their supervisors.*
- *DASH assessments and Claire's Law need to be completed and documented in records.*
- *If a case goes to MARAC this needs to be documented and the actions acted upon.*
- *Staff in health need to raise the subject of domestic abuse at every available opportunity to minimise risk and to ensure this is clearly documented within both the child's and parents' records.*
- *The lived experience of the child and how it impacts them when living in a household with DA must never be overlooked and must be included in Assessments.*

Please take time out today and look at these links. The NCDV offers free training **here**

The Anglia care trust offers free support for DA victims **here**

Suicide Prevention In Suffolk

Every death by suicide can have a devastating impact on families, friends, colleagues, witnesses, frontline staff such as first responders and entire communities. This is even more so the case when it is a younger person. Preventing suicide is a major public health issue and is a priority for health and wellbeing partners across Suffolk because preventing suicide is everybody's business. Suicide rates in Suffolk currently are in line with the national average and there is concern with cost-of-living pressures they may increase.

The Suffolk Suicide Prevention Steering Group has oversight of the strategy and plan to reduced suicides in Suffolk. There is also a CYP sub group that has a plan specifically focussed on children and young people and their families.

Since April 2022 there is now a teal time suspected suicide surveillance system that tracks suspected suicide deaths as they happen and allow Public health to monitor themes and methods so if necessary there can be a coordinated response to minimise the risks of further deaths.

To equip the workforce in Suffolk to be better equipped there is free e-training available. There is more generalist training from the Zero Suicide Alliance. **Free online training from Zero Suicide Alliance** This will equip you with the skills and confidence you need to have a potentially life-saving conversation with someone you're worried about. For professionals across the system there is some HEE E-Training **Self-harm and suicide prevention | Health Education England (hee.nhs.uk)** that is more in-depth.

Because preventing suicide deaths is everyone's business it is important to consider the 'what can I do in my setting' question. In your work, whether at a face to face or strategic level it is helpful to consider the following areas that will help children and young people be more resilient.

In your work:

- Raise awareness of emotional health and the importance of recognising when they need help.
- Support children and young people to develop positive coping strategies.
- Reduce stigma and break down barriers around talking about emotional health.
- Support children and young people in developing their communication skills.
- develop supportive and help-seeking behaviour in young people.

If you want to find out more about how you can help make a difference see **Suicide Prevention - Healthy Suffolk** or contact Graham Abbott **Graham.Abbott@suffolk.gov.uk**

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, 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 :sneeicb-ws.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.