# Learning from Children's Deaths

A newsletter for professionals

**November 2021, Issue 7**

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## 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

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

GET IN TOUCH

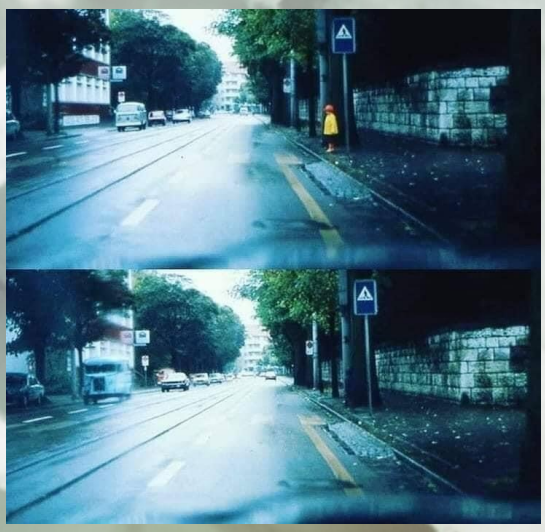
## Introducing Amy Underwood

Hi, my name is Amy Underwood, I have worked for the Suffolk Safeguarding Partnership in various roles since 2010. I am currently the Partnership Coordinator and as part of this role, I support and assist with the administration of ECDOP and the Child Death Overview Panel meetings. There are strong links between the Suffolk Safeguarding Partnership and the Child Death Review Team and its helpful to work across both teams.

In my spare time I enjoy swimming, shopping and participating in my children's hobbies, which keep me very busy.

The work of the Child Death Review Team is invaluable and I feel privileged to be a tiny part of their support.

## DANGERS OF WINTER MORNINGS AND EVENINGS



There is a child in both of these pictures. This is something for parents to think about when they are buying their children's winter coats. Be safe be seen.

If you are a professional working with parents or working in education please share this valuable message.


## Bereavement support following unexpected death of a child – St Elizabeth Hospice

A review of bereavement support in Suffolk revealed that there was a service provision gap in EAST Suffolk where there was limited bereavement support for families following an unexpected child death. This was raised with the local commissioners which has led to St Elizabeth hospice stepping in to fill this gap. All bereavement enquires and referrals for families in East Suffolk will now be co-ordinated through the living grief service at St Elizabeth Hospice. The Inclusion criteria will include: - Family members linked to an unexpected death in an infant or child (less than 18 years), the child who died unexpectedly was a resident in East Suffolk and family members also reside in East Suffolk, the death occurred within the last 12 months. This service will include bereavement support (1:1 support - via telephone, online or face to face), family work and Information provision.

**How to make a referral**: To make a referral please complete the online form Bereavement support referral form - St Elizabeth Hospice. For all other enquiries please call their Living Grief bereavement and emotional wellbeing enquiry line on 0300 303 5196. Monday to Friday 9am-4pm

Further information can be found on their website LivingGrief - bereavement support - St Elizabeth Hospice

St Elizabeth Hospice

LIVINGGRIEF

Let's talk about grief...

## Importance of signposting patients/ families/carer's to PALS

*" I didn't want a pay out for what went wrong with my child's care, I wanted professionals to learn from the incident and to review practice for children with learning disabilities. Because my case went to court and I had a small pay out, I was told it couldn't be talked about so no learning happened when he was alive. I wish I had gone through PALs instead of going down the legal route so that PALs could have reviewed and put learning into place at the time of the incident".*

The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. PALS, has been introduced to ensure that the NHS listens to patients, their relatives, carers and friends, and answers their questions and resolves their concerns as quickly as possible. PALS also helps the NHS to improve services by listening to what matters to patients and their loved ones and making changes, when appropriate. Find out more information **here**

## Calling all GPs

Remember the CDR team are here for you too. If you have a child death on your caseload, including neonatal, expected and unexpected deaths we can help guide you through the process and ensure you are invited to meetings/reviews. If you are unable to attend any child death review meetings, including PMRTs (neonatal deaths), CDR meetings, or SUIDCs, please let us know so that we can attend on your behalf, sharing any relevant information and feeding back to you. If you are worried about any patients who have experienced a Child Death, please give our team a call to discuss further.

## Suicide Awareness

As you may be aware that since March, Suffolk has unfortunately had 3 deaths by suicide in males aged between 10 and 17 years. The National Child Mortality Database has completed a thematic review on national data between 1/4/19 and 31/3/20.

This review highlights the common characteristics of children and young people who die by suicide and found that suicide is not limited to certain groups, regions, deprived or affluent neighbourhoods and suicide rates are similar across all areas of England. One third of all young people who were reviewed had never been in contact with mental health services and a quarter of children and young people had experience bullying either face to face or cyber. The Full report is available here - **Suicide in Children & Young People | National Child Mortality Database (ncmd.info)**

The recent Suffolk cases prompted us to explore the provision for people affected by the death of someone to suicide. A death by suicide is a tragedy and can effect anyone who is aware of the death. This includes professionals, family, and friends. In Suffolk and North East Essex we are fortunate to have a new service called Bereaved By Suicide. If you are aware of a anyone requiring support please do not hesitate to contact the number below.


## Helicopter View – What it means for health professionals?

**'The Helicopter View' helps us to learn to see things differently - see a bigger picture, a different perspective.**

Sometimes it's useful to use a metaphor to help us consider the bigger picture. When something is distressing us, we're so close to it, emotionally involved with it, part of it - that makes it really hard to stand back from what's happening. It's like the well-known saying "We can't see the wood for the trees", or like 'Google Earth' - we see the close up view but we can't see anything else. We can zoom out our view and see the bigger picture. We could call this the Helicopter View.
As the helicopter takes off, getting higher and higher, it sees a bigger and bigger picture, and is less involved with the detail at ground level. So, as we pull back from an emotional situation, we can start to see things much more clearly and rationally. In some of our recent cases, we have seen that professionals are getting stuck on one particular thing, or they are just seeing one aspect of a situation but not the whole thing. Sometimes in these cases we see that children are getting lost in the mix or that their voices are not being heard. They are no longer being listened to or noticed. The helicopter view is a useful tool to help us as professionals consider what is really going on with our caseloads and families we are supporting. For more information see **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 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

## SAFETY NOTICE!!

The Office for Product Safety and Standards (OPSS), the UK's national product safety regulator, has issued a Safety Alert to warn of the risk of serious injury and death from swallowing small high-powered magnets. This follows increasing reports of injuries and a small number of deaths after ingestion of magnets, particularly among children and young people. High-powered magnets in products are of a particular concern, where the magnets can be swallowed, such as toys, fridge magnets, earrings, tongue piercings and drink charms. They are often brought cheaply from online market places. The public is being asked to take appropriate steps to keep these products away from children as ingestion could result in a serious or fatal injury. Parents/guardians should understand the signs of magnetic ingestion and act quickly to get immediate medical treatment if they believe a magnet has been swallowed. In addition, OPSS is working with local authority Trading Standards to identify and take appropriate action against any products where magnets that breach the required level of magnetic flux may be ingested by a child.

The Child Accident Prevention Trust have produced some great information and resources to share with professionals and families which can be seen here [Magnets | Home | Child Accident Prevention Trust (capt.org.uk)](#) this includes some great social media campaigns which you can copy and paste onto your own organisations Facebook/ Twitter/Instagram


## Child Death Overview Panel (CDOP)

The Child Death Overview Panel is held every second month in Suffolk, and twice a year we hold specialised neonatal panels. For the past 18 months these panels have been held virtually, although we are hoping soon, we can have a mixture of a face-to-face meeting with a virtual forum. Professionals' attendance at this panel is very important and a significant part of each child death review that takes place. If you are a professional that attends panel and you are unbale to attend for any reason, please let us know. You are welcome to send a professional in your place on the day. The key functions of a CDOP are to:

- Review all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law
- Determine whether the death was preventable (if there were modifiable factors which may have contributed to the death)
- Decide what, if any, actions could be taken to prevent such deaths happening in the future
- Identify patterns or trends in local data
- Agree local procedures for responding to unexpected child deaths

## CDR Learning Event October 2021—another amazing week for learning


The CDR team held their second learning event from the 11th to the 15th of October, to coincide with Baby Loss Awareness week.

We had some amazing speakers including parents whose accounts of their journey, through losing their child to how they were dealing with on going grief, was very powerful and showed how learning from a lived experience is perhaps the best method of knowing what some of our families are going through at such a difficult time.

Although all of our sessions were well attended we know that due to the busy nature of peoples work lots of our colleagues could not attend. All of our sessions are now available to watch back and listen to **here**

We have already started thinking about our event for next year and we will be working on what it might include and how we can make it as interactive and interesting as possible. Watch this space!!


## SAFER SLEEP FOR BABIES

As the weather turns colder, and people are beginning to venture out to various places, now that Covid has reduced, children and babies are mixing more leading to an increase in mild illnesses. As professionals we may be seeing children more regularly and it is important at this time of year to remind parents and families about safer sleep and to be able to advise parents about good options for sleep if baby is unwell. **All professionals**, (not just midwives and Health Visitors) working with families should share the messages about safer sleeping. Approaches should be tailored, flexible and responsive to the reality of people's lives, which includes talking honestly about how parents will cope in different situations to ensure disruption from a normal routine, can inhibit the ability to adhere to safer sleeping guidance. Co-sleeping in a bed, chair or sofa is not advised.

If you need further information about safer sleep in Suffolk or you are involved with families who could use information or advice you can find out more **here**