Special Edition - 1st Year of CDR Team

A newsletter for professionals

October 2020, Volume 1, Issue 3

In this issue:

Learning from Children's Deaths events

Click on the subject to join the session.

Monday 12th Oct 10-11:30am	SIDS: Where is baby sleeping?
Monday 12th Oct 2–3:30pm	Neonatal Deaths
Tuesday 13th Oct 10-11:30am	Information sharing
Tuesday 13th Oct 2–3:30pm	The Post-mortem
Wednesday 14th Oct 10-11:30am	Bereavement
Wednesday 14th Oct 2–3:30pm	Rare Conditions
Thursday 15th Oct 10-11:30am	Advanced Care Planning
Thursday 15th Oct 2–3:30pm	Impact of Covid-19
Friday 16th Oct 10-11:30am	Professional curiosity
Friday 16th Oct 2–3:30pm	NCMD

Suffolk Child Death Review Team

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

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Team pager: 07623 951892

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Coming soon! Annual Report 2019 - 2020

Look out for the CDR Team Annual Report coming soon!

CDR Nurse - Bernie Spiller's Bio

Hello, I'm Bernie.

I have been a nurse for 22 years. I trained at Great Ormond Street and moved to Addenbrookes some years later. I worked in Paediatric Intensive Care for over 10 years caring for critically ill children and their families. In 2014, I accepted a job back in London, to do a specialist safeguarding role in a busy NHS trust. Commuting every day was difficult but I loved the job! I had never worked in Suffolk despite living here since 2005, so when I saw the CDR role, I applied. The job is varied and I still get to work with families which I love. It can be mentally tough at times but we have a fantastic team and good support from many professionals including police, hospital staff and many more. The work we do is so important and helps join a lot of puzzle pieces together so it's extremely rewarding.

Look out for other team bio's in future issues.

Reminder of Child Death Review Processes

We have now been operational for 1 year and we thought this would be a great opportunity to revisit the core principles of the Child Death Review process and to share with you a little bit about our team.

Most of you involved in children's deaths hold one piece of the puzzle and historically it was difficult for CDOP to bring these pieces together. These are obtaining the information needed to meet the statutory responsibilities, understanding what has happened and extracting the learning. There was a similar picture across the UK along with a countrywide concern that there was a lack of bereavement support for families. As a response to this, our team came into post to help deliver the new Child Death Review Statutory and Operational Guidance which sets out key features of what a good child death review process should look like, to ensure standard practice nationally and enable thematic learning to prevent future deaths.

Working alongside the guidance, our aim is to:

Improve the experience of bereaved families, as well as professionals, after the death of a child; and

Ensure that information from the child death review process is systematically captured to enable local learning and, through the planned National Child Mortality Database, to identify learning at a national level, and inform changes in policy and practice regarding deaths.

Child Death Overview Panel (CDOP) – this is the last stage in the child death review process.

Suffolk Safeguarding Partnership (SSP) is responsible for ensuring that a review of each death of a child normally resident in Suffolk is undertaken by CDOP. The Suffolk CDOP has a fixed core membership drawn from organisations represented on the SSP, the panel is held 6-8 times a year which includes a new themed neonatal panel.

In Suffolk the Child Death Review Nurse presents each case (anonymised) using information that they have collated through the Child Death Review process. The main purpose is to learn how to try and prevent future deaths. The panel makes recommendations and reports on the lessons learned to the Suffolk Safeguarding Partnership.

Unfortunately, parents are not invited to the CDOP panel but the CDR Nurse asks all parents if they would like to contribute any comments prior to the meeting and have the option to have the learning shared with them following the meeting.

Click here for more information on the function of the Suffolk CDOP.

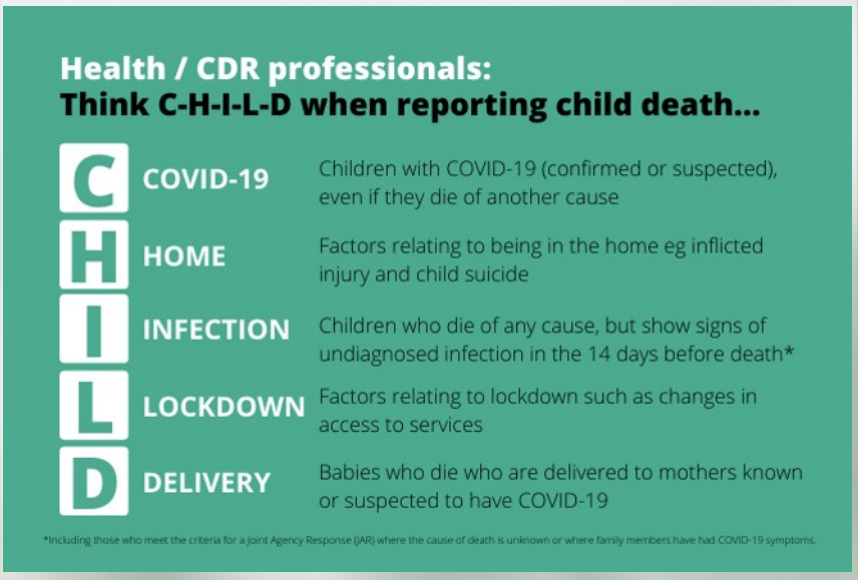
If you would like to receive this newsletter, please click here to sign up.

Reminder of Child Death Review Processes (continued)

COVID-19 - How can you help?

It is vital that health and social care continue to ***complete CDOP notifications within 48 hours of death*** and when COVID-19 could have been a factor this must be recorded. Please think beyond COVID-19 symptoms to help the NCMD fully understand the impact of the virus on children; think C-H-I-L-D when reporting a child death.

For all deaths (neonatal, expected and unexpected) please page the



How to Notify Child Death Review Team/CDOP of a Child's Death

CDR Team on the Team Pager Number: **07623 951892** and fill in the eCDOP notification form found here within 48 hours.

eCDOP notification forms:

The statutory Child Death notification form is arguably the most important form in the whole Child Death Review (CDR) process. Not only does it notify the CDR Team/CDOP/NCMD of the death of a child but, when completed well, it can also provide a comprehensive list of all those professionals who cared for the child during their life and immediately after their death. It is this list which enables the CDR Team to carry out the rest of the process. Without it, gathering information about the child is very challenging. By completing a notification form well, you will make an enormous difference to the process.

New changes to eCDOP notification form

The new form includes specific questions relevant to the fight against COVID-19 that are now needed at the point of notification of death. Some of these questions are new and some you will recognise from the Reporting form. The New alert function enables you to highlight, in real time, issues that are time critical, and where prompt wider communication to health and social care professionals could reduce deaths. This includes, deaths relating to COVID-19/lockdown, any death where an urgent, national public safety message is required e.g. home safety for children such as the use of blind cords and nappy sacks, a problem with a product design e.g. car seats, equipment malfunction, adverse drug reaction or other sentinel event in relation to the child's death.

Joint Agency Response (Jar)/SUDIC for child deaths during

COVID-19

During the COVID-19 pandemic, the central aims of the Joint Agency Response/SUDIC still apply. While the circumstances in which JAR/SUDIC is required are unchanged, how they are enacted may need to change depending on circumstances. National guidance from the NCMD on this can be found here.

Remember Routine Kennedy samples (as agreed with the local Coroner) including an airway and rectal swab for Coronavirus should be taken for all child deaths, with appropriate use of PPE. The results of the viral swabs will determine where and with what precautions the post-mortem will take place.

NEW link with BadgerNet

To support the national surveillance of the effect of COVID-19 in babies and children under neonatal care, the NCMD are establishing a link with the BadgerNet maternity system. More specifically, this will enable a direct feed of clinical information around deaths in a neonatal setting. Please note: ***NCMD data linkage with BadgerNet does not replace the child death review eCDOP notification process***, which remains a statutory requirement.

Safety notices:

The NCMD are now publishing safety notices on their website, this is what they have published so far, for more information and to see future notices visit their website.

- **Masks/face coverings:** Not considered suitable for children, particularly children under three years' old, where they can be dangerous (current guidance from Public Health England).
- **Blind cords:** Dangerous to young children and babies as they can cause strangulation (they MUST be kept short and out of reach).
- **Nappy sacks:** These are extremely dangerous to babies and young children as they can cause suffocation. They must be kept out of reach and out of the baby's cot.
- **Keep it simple, keep it clear:** With equipment for babies, always follow the manufacturer's instructions and avoid enhancements unless specifically recommended. With cots, it is safest to keep them clear of any items such as bumpers, toys and loose bedding.

Goodbye Karen...

At the end of October, we regretfully say goodbye to our fantastic business administrator Karen Ghosh who is a big part of the CDR team. She was a big part of collating all the thoughts, ideas and processes together when the team was first formed, and sorting out what we needed and when. She has helped the nurses establish the smooth running of what happens when a child dies and who does what. Always smiling and happy to help or just be a listening ear the CDR team just won't be the same. We wish her every success in her new role.

Produced by the Child Death Review Team, Suffolk, NHS Clinical Commissioning Group, Endeavour House, Russell Road, Ipswich, IP1 2BX