ISSUE NO.1 February 2022

NEWSLETTER

Norfolk and Waveney Clinical Commissioning Group

CHILD DEATH REVIEW TEAM

Welcome to the first issue of the Norfolk and Waveney Child Death Review Team newsletter.

The Child Death Review (CDR) Team was launched in April 2021 and replaces the Rapid Response Team which worked out of the Norfolk and Norwich University NHS Trust from 2009-2021. The CDR Team cover the whole of Norfolk and Waveney including the 3 acute hospitals James Paget, Queen Elizabeth and NNUH. The team is available Monday to Friday 08:00 to 18:00 (excluding bank holidays).

The team responds to expected and unexpected deaths of children up to the age of 18 years ensuring that statutory guidelines are followed. The Team provides a robust service spending time supporting families and working closely with professionals from all agencies to ensure that a comprehensive multi-agency information gathering process is carried out.

Information gathered from each death is entered into the eCDOP system and presented every two months to both Norfolk and Suffolk Child Death Overview Panels, with multiagency representation. The panel members review each death looking at whether there are modifiable factors and from these what lessons can be taken forward to produce learning and future prevention. Information from CDOP is fed back to the National Childhood Mortality Database NCMD. Home 2021 - National Child Mortality Database (ncmd.info) .

MEET THE CHILD DEATH REVIEW TEAM :

Hi, I am Sonia Furness and am the Lead Nurse for Child Death in Norfolk and Waveney. Prior to this I was a Paediatric Nursing Sister with 26 years' experience. Since 2009 I have responded to Sudden and Unexpected Death in Childhood, doing this alongside my clinical role. The newly formed Child Death Review Team was formed in April 2021 and as such we are now able to provide a really robust service.

The team have a wealth of experience in the nursing arena, ranging from the Acute to Community Paediatrics. We sit alongside the Designated Safeguarding Children Team, and work across the provider Trusts with a range of agencies and service providers including police, education, social care and the Hospice movement. Whilst taking a systematic and sensitive approach to all investigations and reviews we never lose sight that the lost children and their remaining families remain central to everything we do.

In addition to the response process, we are able to provide teaching and support to professionals involved with children.

Creativity in the garden and kitchen help me to thrive. We are privileged to have 25 acres of wood and meadow land, and our rescued battery hens are truly free range. Within the land we have organic vegetable beds using permaculture principles such as the hugelkutur. Next year we intend to start bee keeping within the forest.

Next issue to include:

-Repeat prescribing

-Professional curiosity / Importance of Listening

-Smoking cessation

-Spotting the Sick Child

-Deprivation

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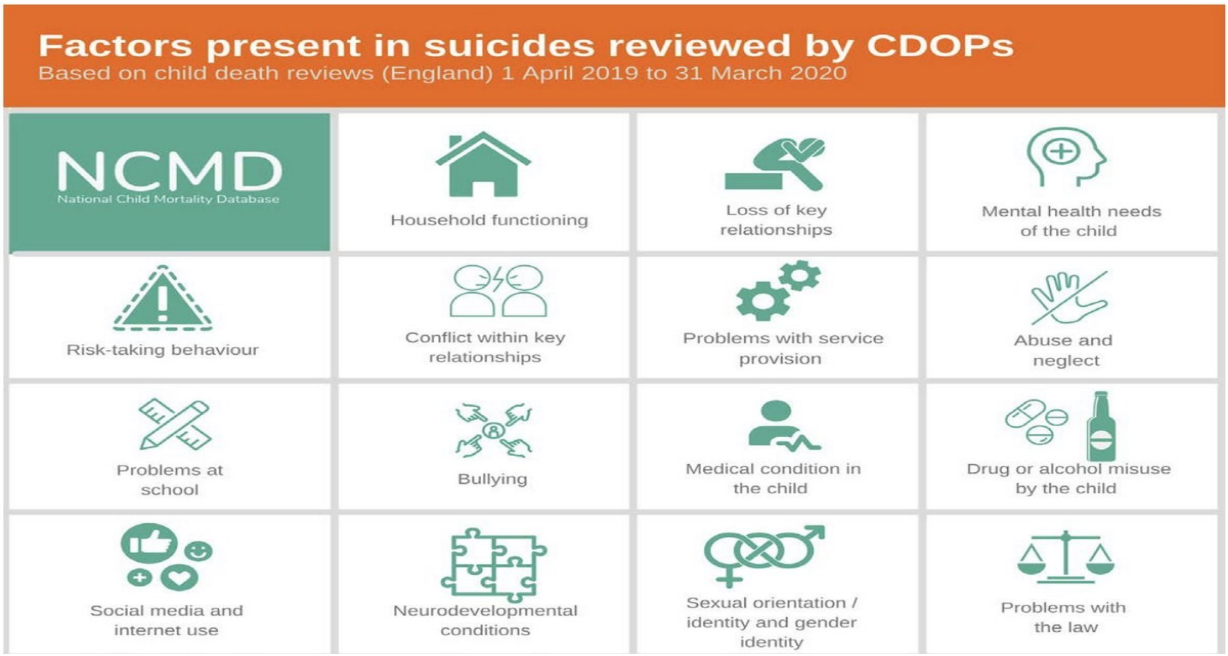
Local learning from deaths…

In the local area over the past year there have been 3 children who have very sadly died by suicide (NB we no longer use the term 'committed suicide'). At the local CDOP the importance of supporting young people around who to talk to if they feel suicidal and supporting those who they have spoken to was identified as important and a local tool for schools to support young people in knowing who they can to talk to is being developed. The NCMD report analysed data from deaths of children between April 2019 and March 2020 who died by suicide and identifies common in factors present in their lives. Suicide in Children and Young People (2021) https://www.ncmd.info/publications/child-suicide-report/ This report identifies key learning points for use in practice:



Key Learning Points:

- Importance of joint working and information sharing between agencies working with children/young people with mental health issues. And importance of information sharing with parents/carers.
- Lack of confidence for professionals to talk about suicide with young people.
- Importance of safe and accessible spaces for children/young people to talk about their mental health and well being to ensure their voices are heard.
- Recognition of the impact of social factors such as domestic violence on mental health and well being of children/young people.

Railway Safety #Iamtrainsafe

Due to the very high level of trespassing on the tracks by young people in your local area, Network Rail in partnership with Learn Live are working to help raise awareness to students across the UK educating them about the dangers of the train tracks through interactive digital delivery. Over 12 million students, parents and teachers from across the UK have watched these videos which has led to a significant decrease in the number of trespasses in their area through watching the safety videos:

https://learnliveuk.com/network-rail-primary-school-safety-talk/

https://learnliveuk.com/i-am-train-safe/

Enter email:railsafety@learnliveuk.com

Fire Surrounds

We have been notified of two child deaths nationally in 2021 caused by life changing traumatic injuries associated with falling fire surrounds. There is limited UK based research on this issue however there are many cases reported via national media of children under the age of 7 years who have been killed by falling fire surrounds that have not been professionally secured. Practitioners working with children and their families need to increase awareness of the risks of unsecured furniture, televisions and fire surrounds when: https://www.rospa.com/home-

National learning focus: the team have been looking at...

The Myth of Invisible Men (2021): The Myth of Invisible Men (publishing.service.gov.uk)

A safeguarding review by The Safeguarding Practice Review Panel (2021) focusing on babies under the age of one year that have been harmed or killed by fathers or male carers. To make work with fathers more effective; gain greater understanding about the men's lives and behaviour including factors that precipitate abuse. The review looks at how well services engage with men, their functioning allowing men to be absent, not maximising opportunities to identify and respond to risks that some men present.

The review shows links between domestic violence, mental health issues, substance misuse, young parents, care leavers and poverty and debt and death from abusive head trauma in babies.

The report highlights the importance of professionals that see male patients and identify concerns relating to mental health, domestic violence, debt problems who have children or where their partner may be pregnant to share there information with Midwifery or Health Visiting services. This information gathering and sharing will create a more 'rounded and fuller' picture of what life is like for a family and the children within.

Recommendations: Develop ante-and-post-natal health provision to include fully fathers, providing extra support to fathers when needed and increase ability to identify risk factors early. Better integration of adult and children service provision especially mental health services and substance misuse.

The report recommends the website https://iconcope.org/parentsadvice/. This website contains useful information for parents and professional including an information video for parents about what to do when their baby cries: Parents Advice | ICON (iconcope.org)

It was identified at the local CDOP the importance of being able to identify Fathers and male carers within the house hold: Please remember to add the name and date of birth of fathers/male carers to the child's records.

Ockenden Report (2021): https://www.ockendenmaternityreview.org.uk/

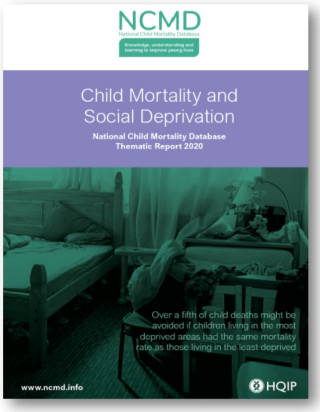
A clinical review of 250 family cases from 2000-2018. The review recommends actions and change following avoidable deaths of mothers and their babies namely Kate in 2009 and Pippa in 2016.

Highlights lack of compassion and kindness by staff:

⇒ Errors in foetal monitoring
⇒ Poor management of high risk pregnancies and failure to escalate for further opinion and review.
⇒ Failure to learn from serious incidents.
⇒ Foetal heart rate monitoring
⇒ Keeping C section rates low causing injury and death of mothers and babies
⇒ Importance of bereavement care.

NCMD Report: *Child Mortality and Social Deprivation* 2021

REPORT: Child Mortality and Social Deprivation - National Child Mortality Database (ncmd.info)



Based on data for children who died between April 2019 and March 2020 in England finds a clear association between the risk of child death and the level of deprivation. On average there was a 10% increase in risk of death between each decile of increasing deprivation.

The proportion of deaths with identified modifiable factors increased with increasing deprivation. The main theme identified was housing issues: lack of cleanliness, unsuitability e.g. overcrowding, maintenance issues (e.g. Damp/mould) and also financial problems and debt.

Over a fifth of all child deaths may be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived. This equates to over 700 fewer children dying per year.