NHS
Norfolk and Waveney
Clinical Commissioning Group

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NEWSLETTER

CHILD DEATH REVIEW TEAM

Welcome to the second issue of the Norfolk and Waveney Child Death Review Team newsletter. The Child Death Review Team have been up and running for one year responding to unexpected deaths in childhood and providing valuable support to bereaved families.

MEET THE CHILD DEATH REVIEW TEAM:

"Hi, I am Chris Small and I am the Chair of the Norfolk Child Death Overview Panel (CDOP). CDOP is a multi-agency panel which reviews the deaths of all children who live in the area. It is the final piece of the child death review process and meets every other month. The main purpose of CDOP is to capture the expertise and thoughts of all individuals who have interacted with a case in order to help us all, especially parents or carers, to understand what happened, learn lessons and share any findings to contribute towards the prevention of future deaths. My role is to manage the CDOP meetings effectively, ensure the lessons learnt are analysed and recorded and summarise these in an annual report. About half of all child deaths are babies that die during the first 28 days of life, many in the first week after birth and so at least twice a year we meet as a specialist neo-natal panel to consider these cases.

The death of a child is a devastating loss, that profoundly affects bereaved parents as well as siblings, grandparents, extended family, friends and professionals who were involved in caring for the child in any capacity. The process of expertly reviewing all children's deaths must be grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths. Families experiencing such a tragedy should be related to with empathy and compassion.

I took over as CDOP Chair in June 2021, having spent the previous forty years in social work. I returned to Norfolk in 1987 and from 2000 worked as a manager and leader in Norfolk Youth Offending Team with young people who had come to the attention of the Police or the Courts.

I live to the east of Norwich with my partner of 20 years and have four 'children' aged between 31 and 37, and two grandchildren. I spend much of my increasing free time watching and recording the birds and wildlife of this beautiful county and country and can often be found ambling about in the marshes of the Yare Valley.

I work very closely with the Child Death Review Team, the Designated Doctor for Child Death and the Norfolk Safeguarding Children Partnership Child Death Overview Panel Administrator, as well as all the members of the Multi-Agency CDOP and have really enjoyed getting to know and developed a high regard for, colleagues working in this field."

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Lead Nurse Sonia Furness; Deputy Nurse Julia Fothergill, Deputy Nurse Anne-Marie Freeman

HSIB Spotting the sick child (2021)

Report to improve patient safety in recognition of acutely ill infant and child. Mohammed was a 3 month old baby that died of septicaemia. The subsequent investigation's core objective was to understand decision making and why decisions made sense to the clinicians at the time. The investigation sought to understand how work demands and constraints in the healthcare system, as a whole, interacted to influence the way staff worked on the night of Mohammad's admission.

Key points:

- Distinguishing between simple viral illness and life-threatening bacterial infections.
- Infants or children who have fever without apparent cause are of particular concern.
- Important to identify early signs/symptoms that could lead to sudden
- deterioration.
- Quick diagnosis is important as their heath can deteriorate rapidly.
- **Importance of listening to parent's concerns.**
- Early warning score to include parental concerns.
- **Clinical judgement and professional curiosity.**
- Recognition of acutely unwell infants is Complex.
- Assessment of skin colour and carers being asked if patients are 'pale' or if their lips have 'turned blue' are not useful approaches for patients with non-white skin. In addition, descriptions of rashes focus on redness or paleness, both of which are more difficult to recognise in a patient with non-white skin; importance of skin colour in triage.

Clinical experience and judgement remain essential for the detection of deterioration in an infant or child whose vital signs are within, or only slightly outside the expected ranges.

The use of medicines to reduce temperature may mask the symptoms of serious illness in infants and children.

Paediatric Early Warning Scores (PEWS) systems are widely used around the world to monitor health of infants and children, however there is a lack of consensus about which system is most useful. There is no early warning score that will always detect deterioration in infants or children. **In one of our forthcoming newsletters we will share a new observation chart being developed at the NNUH, which includes and recognises the importance of parents voices and clinical intuition of professional caring for the patient.**

https://www.hsib.org.uk/investigations-and-reports/recognition-of-acutely-ill-infant/

Child Bereavement UK

This is a UK charity helping children, young people, parents and families rebuild their lives when a child grieves or when a child dies.

They offer free confidential bereavement support by telephone, video or instant messenger anywhere in the UK

https://www.childbereavementuk.org/?gclid=EAIaIQobChMI_szLud7X9wIVzcLtCh15RwWjEAAYASAAEgJ_kPD_BwE

Stopping smoking in pregnancy

In the Annual Report for the Norfolk and Suffolk Child Death Overview Panel (2020-2021), 48% of all child death notifications were neonates and 13% were infants (28 and 364 days old). In neonatal cases 34% of these cases were identified as having modifiable factors; **Factors which *may* have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to *reduce the risk* of future child deaths.**

One important factor was parents smoking during pregnancy, which is a contributory factor in deaths from premature delivery. Infants had the had the highest proportion of deaths (46%) being assessed as having modifiable factors. Again, smoking emerged as a possible contributory and modifiable factor.

The National Child Mortality Database, identified in their annual report of the same year that across all categories of death, smoking by a parent or carer was the most frequent modifiable factor. https://www.ncmd.info/wp-content/uploads/2021/06/NCMD_2nd_Annual_Report_June-2021_web-FINAL.pdf.

It is therefore important for all professionals to continue the endeavour to encourage women to stop smoking.

The NICE guidelines on treating tobacco dependence in pregnant women aim to help women stop smoking when pregnant and in the first year after childbirth. The guidelines recommend routine Carbon Monoxide testing at all antenatal appointments to assess the pregnant women's exposure to tobacco smoke. Providing an **opt out** referral to receive stop smoking support for all pregnant women who smoke, have stopped smoking in the last two weeks or have a carbon monoxide reading above 4 parts per million. https://www.nice.org.uk/guidance/ng209/chapter/Recommendations-on-treating-tobacco-dependence-in-pregnant-women.

It is important for the woman to know that it is normal practice to refer all pregnant women who smoke or have recently quit. That Carbon Monoxide test, will allow her to see a physical measure of her smoking and the exposure to other peoples smoking and explanation of what her carbon monoxide reading means. Nicotine Replacement Therapy should be considered at the earliest opportunity in pregnancy and continue to provide it after pregnancy to prevent relapse.

Offer pregnant women's partners, parents and other household members who smoke help to stop: Encourage them to stop if they are present at appointments and refer them to a local Stop Smoking Service, if they want to stop or cut down. Provide clear advice about the danger of smoking and second hand smoke, including to pregnant women and babies before and after birth. Recommend not smoking around the patient, pregnant woman, mother or baby and not smoking in the house.

https://www.smokefreenorfolk.nhs.uk/

https://onelifesuffolk.co.uk/services/stop-smoking/

https://www.nhs.uk/live-well/

Dads Still standing: "something for the Dads that have lost by Dads that have lost" Dadsstillstanding@gmail.com

This is a website created by Matt and Liam; two bereaved Dads. They produce regular podcasts discussing all aspects of their grief journeys to help Dads along their journey with grief, discussing the difficulties in the immediate after math of losing a baby/child and as time moves on.

NB. Remember the importance of gaining information about Dads and how they are coping with the death of their child/baby.

Are you a Prescriber?

Repeat prescriptions: Following an unexpected death of a child one of the nurses from the Child Death Review Team will complete a joint home visit with the police. The police and nurse will look around the home of the child. During a recent home visit following the sad death of a child lots of prescription medication was found in the home; there was enough prescribed medication to fill 4 black bin bags. The medication had been prescribed for both the child and the parents. There were many boxes of un-opened prescription medication for the child. This raises questions that can inform our practice:

How often are prescriptions reviewed for children and which professional involved in the child's care is responsible for reviewing the medication? Children on medication for mental health issues who have been discharged from Mental Health Services require regular review of medication.

Medication reviews: Are a structured, critical examination of a persons medicines with the objective of optimising the impact of medicines, minimising medication related problems and reducing waste https://www.nice.org.uk/guidance/ng5/chapter/1-Recommendations#medication-review.

It is recommended that patients who are taking any medications on a long-term basis, should have their medications reviewed annually with a pharmacist or an appropriate health professional who is part of the multi-disciplinary team.

The following situation would indicate that it is time for a review:

- Children and young people taking multiple medicines.
- More than one medication to treat a health problem.
- Children and Young People with chronic or long-term conditions.

The benefits of medication reviews:

- Avoid dangerous medication interactions
- Eliminate duplicate medicines and excessive doses
- Optimise adherence
- Stay informed
- Receive professional care
- Discuss health changes
- Safely dispose of unneeded medications
- Improve satisfaction and quality of life
- Reduce costs

News and updates:

Child Safety week 6th June -12th June 2022

https://www.capt.org.uk/