SUSSEX CHILD DEATH REVIEW PARTNERSHIP

Newsletter

Issue No. 4 | October 2021

Welcome to the fourth edition of the Pan Sussex Child Death Review Partners (CDRP) newsletter. In this edition we have a focus on Child Death Notification and CDOP Learning.

News and Updates

National Child Mortality Database have recently published their second annual report which highlights for the first time the most frequently reported modifiable factors, which align with findings from Sussex reviews. The top three are:

1. Smoking (parent/carer)
2. Quality of service delivery
3. Unsafe sleeping arrangements

Baby Sling Safety Advice has been produced by the Consortium of UK Sling Manufacturers and Retailers. We would encourage frontline practitioners to share their acronym with parents and carers:

Tight
In view at all times
Close enough to kiss
Keep chin off the chest
Supported back

Child Safeguarding Practice Review Panel have published their national review that looks at safeguarding children under one from non-accidental injury caused by male carers. The review highlights that men with a background of abusive, neglectful or inconsistent parenting themselves heightens the risk of abuse and can lead to poor mental health. This is often exacerbated by substance misuse, domestic abuse, inequalities and very problematic relationships with the mothers of their children.

Healthcare Safety Investigation Branch undertake systematic patient safety investigations under their national and maternity investigations programmes. Their recently published report contains thematic analysis of their first 22 national investigations and three recurring themes that represent the most significant threats to patient safety:

- Access to care and transitions of care (when patients move between care providers or care settings)
- Communication and decision making
- Checking at the point of care

Want to be on our mailing list? Sxccg.cdrteam@nhs.net

Focus on … CDOP Child Death Notification

CDOP Notifications

The start of the child death review process begins with the formal notification form being submitted via eCDOP **within 24 hours** of the death occurring, usually by a member of staff from the organisation whom has confirmed the child's death. A well completed notification form strongly supports the child death review process.

- A fully completed notification saves time for all professionals involved. If lacking information, we will contact you for further details.
- The information provided supports both the CDOP process and the wider CDRT team whom are likely to be involved with the families.
- Details box - Please be as descriptive as possible. It is **essential** there is a written summary of what is known around a child's death, and steps that will be taken in response i.e. additional investigations, and bereavement support plans.
- The submitted information is sent onwards to the NCMD as part of the real-time surveillance and analysis of child mortality across England.
- Relevant Agency Contacts - provides holistic information about the child, the family, and the professionals who know and have been working with the family. If absent this causes a delay while this information is gathered.
- If all the above information is included this enables a more effective and informed child death process from the outset.

If you need any support with completing the notification form, please contact our CDOP team during working hours (Monday-Friday) who will be happy to help.
Thank you all for the cooperation and support.
Mike Newman, CDOP Manager – Tel: 07768 555 701; Team email: sxccg.cdop@nhs.net

CDOP Learning

Safety For Families Traveling Abroad

In Sussex, we have had several children die abroad where not using a car seat has been identified as a modifiable factor. As families are now increasingly travelling abroad again, it is timely to highlight to parents the need to consider child travel safety when discussing foreign travel plans. The World Health Organisation recognises road traffic injuries as a major public health problem and a leading cause of death and injury around the world.
UK law requires that children must use a child car seat until they are 12 years old or 135cm/4ft 5in tall, whichever comes first. However, these rules and regulations vary considerably in other countries. Parents should be advised to check with their airline if they can take their child's car seat. Most airlines do not charge for this and it is standard practice for many.

The UK Government has produced a guide which highlights some of the main ways people can help to stay safe abroad and **importantly**, what help the Foreign Commonwealth & Development Office can offer when something goes wrong.

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CDOP Learning

Hospital Discharge

Any child who is discharged from a tertiary centre into the community with a complicated medical diagnosis can be very challenging for professionals to manage. Communication between professionals during such transitions of care has been highlighted in Sussex reviews as an area where gaps in practice have had an impact on the care children have received. All services and professionals with a child need to have a shared understanding of the care already provided and the ongoing care plan to ensure fully joined up care. In one case reviewed, assumptions were made (incorrectly) about parents having received CPR training before discharge for a child with congenital heart disease.

Recognition of Sepsis

The critical importance of health professionals adhering to policies and procedures relating to sepsis in children (0-17 years) cannot be underestimated. In one case reviewed, a child (or their parent) had multiple contacts with primary care about the child being unwell where the clinical assessment did not identify any indication to refer to hospital. Learning from this case highlighted that the threshold for referring an unwell child to acute paediatric services should be lowered when there are an increasing number of health contacts or face to face consultations.

Further information about sepsis can be found on The UK Sepsis Trust website.

Cardiac Syncope

Learning from a case reviewed involving a child with a history of syncope who excessively vaped and died suddenly of sudden cardiac syndrome highlighted that clinicians should:

- ensure they are familiar with the clinical signs of syncope
- if red flags are present (frequent episodes, those related to exercise, presence of other cardiac symptoms, a family history of sudden deaths, sensorineural deafness, cardiomyopathy and documented dysrhythmias) an ECG should be performed and referral to paediatric services for further assessment should be made.

Training

Pan Sussex Safeguarding Under 5's Virtual Conference

Date: Tuesday 30th November 2021
Time: 0930—1530

Request your place!

Topics include:
Out of Routine (Sudden Unexpected Deaths in Infancy), National Review Panel Infant Mortality and Parent & Infant Relationships (impact on child mental health and development)

Key contacts:

CDOP Team: Sxccg.cdop@nhs.net

CDR Nursing Team: sxccg.cdrteam@nhs.net