Learning from Children's Deaths

A newsletter for professionals **January 2025, Issue 19**

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Please see the NCMD website for more information on national learning from Child Death Reviews and access to free webinars and events

NCMD | The National Child Mortality Database

Suffolk Child Death Review Team

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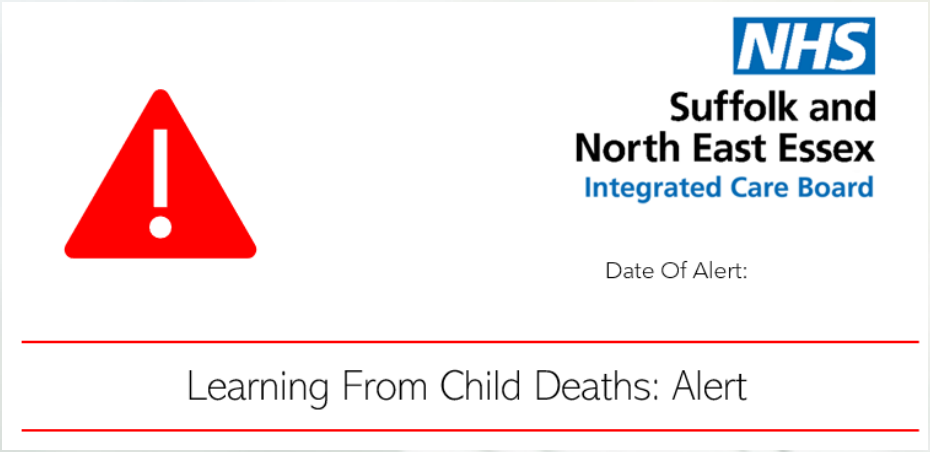
Learning Alerts – NEW!!!

Keep an eye out for our new learning alerts coming into your inbox. To be able to share information in a timelier manner we have created a Learning Alert template which will allow us to send out a summary of local and national learning alerts – this will include sharing Prevention of Future Death reports and national safety notices from the National Child Morality Database and other Child Death Overview Panels.



Sling Safety

A West London coroner has raised concerns with sling/baby carrier safety advice following the death of a six-week-old baby who was being carried around at home in a sling but unfortunately too low down causing suffocation. It is recommended that the TICKS acronym be shared to promote safe use of slings and baby carriers.

https://babyslingsafety.co.uk/ticks.pdf

REMINDER!! Neonatal notifications – introduction of the new CASCADE system from January 2025

When a neonatal death occurs (babies born alive who die within 28 days), notifications need to be made to multiple organisations including MBRRACE-UK for national perinatal mortality surveillance, local Child Death Overview Panels (CDOPs) and the National Child Mortality Database (NCMD).

The purpose of the Cascade integrated system is to reduce the duplication of data entry by those who need to make notifications of neonatal deaths. The system works by trusts completing a notification to MBRRACE-UK when a neonatal death occurs. The system will automatically determine which of those notifications need to be sent onward to CDOPs and which CDOP needs to know that the death has occurred. It will then send that notification to the relevant CDOP.

Deaths of liveborn babies who are born at less than 20 weeks gestation, unattended stillbirths in the community, and neonatal cases following the SUDIC policy need to be notified to eCDOP directly in the normal way via

https://www.ecdop.co.uk/NorfolkSuffolk/Live/Public

REMEMBER: CDOP does not need to know about terminations of pregnancy even if liveborn.

Death's From Drowning

The Royal Life Saving Society UK (RLSS UK) is a leading charity in water safety, and following recent findings, is urging healthcare professionals and others working with families to help raise awareness of the risks associated with water in the home, with an initial focus on bathtime.

The charity's warning comes as its latest Child Drowning Update reports that a total of 125 children have drowned in the last four years, including 51 at home.

The NCMD has highlighted that the number of child death's from drowning has doubled in the last 4 years. And that one child a month drowns at home in England. In 86% of cases, the child was unsupervised at the time of the incident.

What are the messages we need your help to deliver to parents/carers?

- Always keep young children within arm's reach in the bath. Always keep children under constant adult supervision in the bath. If you need to leave the bathroom, take the child with you.
- Never leave your child under the supervision of child siblings in the bath. If you need to leave the bathroom, take the child with you.
- Drowning can happen quickly and silently – in a matter of minutes. You won't hear that something is wrong.

Please see below a link to the Child Drowning update report for further information.

Child Drowning Update September 2024: England | Royal Life Saving Society UK (RLSS UK)

Action to Prevent Future Death Report (Regulation 28)

Following an inquest or investigation into a death, a coroner may issue a Regulation 28 Prevent Future Deaths (PFD) report to a person, organisation, local authority, government department or agency, where the coroner believes that action to address some of the identified concerns should be taken to prevent future deaths. Receiving individuals or organisations have a statutory obligation to respond to the coroner's PFD report and a deadline of 56 days to do so. Extensions may be requested from the issuing coroner but may not always be granted. It is the responsibility of the Chief Coroner to publish PFDs and their responses on the Courts and Tribunals Judiciary website alongside the publication and redaction policy.

NHS England have a Regulation 28 working group which is an internal, multi-professional group comprising doctors, pharmacists, nurses and a range of other senior clinical, quality and programme/policy colleagues. There is also senior representation from each of the 7 NHS regions. The Working Group undertakes the following:

- Meets to discuss all NHS England responses to PFDs and undertake due diligence
- Shares insights with systems/ICBs
- Tracks and monitors actions required, and
- commitments made within responses
- Considers if additional actions need to be taken or escalations made
- Undertakes thematic reviews into emerging themes or issues
- Produces an annual report each year analysing PFDs received and reviewing responses and themes

Since the CDR team launched in 2019 there have been 4 prevention of future death reports dating between 2023 and 2024. These can be accessed on this link -

You searched for - Courts and Tribunals Judiciary.

Click on "View all reports to Prevent Future Deaths (PFDs)" then search "Suffolk" in keyword box, select child death for PFD Report type then apply.

Deaths of children in need | Children's Commissioner for England

New analysis for the Deaths of children in need | Children's Commissioner for England report estimates that deaths of children in need in 2018-19 to 2022-23 were four times more likely to be due to deliberately inflicted injury, abuse or neglect than the deaths of children without any social care involvement. These children were 'children in need' but were not looked after, and were not on child protection plans, meaning they may have been awaiting an assessment, being assessed, or on a child in need plan. Children previously known to social services, but not at the time of their death, were even more likely to die for these reasons – six times more likely than children not known to services. These findings are only exploratory but indicate that children with intensive types of social care involvement may be being effectively safeguarded from the most lethal abuse and neglect, with the risk instead falling on children with lesser or previous involvement. New analysis for this report estimates that children in need make up a disproportionately large percentage of all child deaths. This proportion may be growing.

The Children's Commissioner is calling for:

- A change in the law that gives children equal protection from physical assault to adults. The current defence of reasonable chastisement or punishment to a charge of assault on a child should be removed – sometimes referred to as a 'smacking ban'. This would bring England in line with the rest of Great Britain. It would not create a new offence but would give children equal protection from violence as adults.
- Schools to be at centre of safeguarding arrangements. Schools should be the fourth statutory safeguarding partner, in recognition of their role in protecting the children who they see every day and the additional insights and data they can contribute about vulnerable young people. They should continue to maintain accountability for children for a year when they are removed from school to be home educated
- Greater oversight of home-educated children. No child who has ever been known to children's social care due to concerns around abuse or neglect should be taken out of school for the purposes of being home educated without the prior agreement of the local authority. For children with a social worker or for whom there is a live referral to children's social care, home education should not be permitted.
- A register of children not in school to be implemented urgently. This must include children who are home educated and be introduced via legislation as a matter of urgency, backed by the resource to effectively implement and monitor it.
- Improved data sharing: A shared unique child identifier should be introduced and, in the first instance, the government's upcoming Children's Wellbeing Bill should stipulate what data should be proactively shared with safeguarding partners. That should include ensuring Border Force data is shared with local authorities and schools when children leave and enter the country.
- National thresholds of need for children in need. Through a review of the Children Act 1989, there should be national guidance set out that defines consistent thresholds of need that children and families must meet to be offered support through a child in need plan, under section 17

Learning Disabilities

Recent cases have highlighted the challenges professionals can face in assessment, diagnosis, and treatment for children with a learning disability and the impact this has on the experiences and outcomes of children and families.

The 'National Paediatric Early Warning System Observation and Escalation Chart' (PEWS) – recognises that learning disabilities is an additional risk factor for children and is included within the PEWS chart to be considered on assessments.

We would like to re-circulate the National Child Mortality Database Programme Thematic Report for reading and learning:

Deaths in children with learning disabilities and autistic children

Teaching

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 are hoping to continue to be part of organised study days in trusts and organisations in 2025, 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:

child.death.review@snee.nhs.uk.

These sessions are a great opportunity for us to talk to staff about particular cases and families which they may have had involvement with.

NCMD January 2025 Updates

Child deaths due to asthma or anaphylaxis

The latest NCMD thematic report uses our unique data to investigate deaths in children due to asthma and anaphylaxis. At the link below you can read the full report, foreword, supporting material and the easy-read report.

Child deaths due to asthma, anaphylaxis and allergies

Child Death Review Data Release: Year ending 31 March 2024

The data in this report summarise information about child deaths in England up to 31 March 2024 and the findings of reviews carried out by a CDOP on or before 31 March 2024.

Child death data release 2024 | National Child Mortality Database

Preventing Sudden Unexpected Deaths in Infancy for families with infants at increased risk

In this blog University of Bristol Research Associate Dr Anna Pease discusses the latest findings around safe sleep for babies, and the relationship between sleep and SIDS.

Preventing Sudden Unexpected Deaths in Infants

Updates for child death review professionals

Multi-agency responses to serious youth violence: working together to support and protect children

This new government research advocates for a public health approach, an intersectional approach, and coordinated community response to tackle youth violence.

Multi-agency responses to serious youth violence: working together to support and protect children - GOV.UK

Cascade Integrated System Guidance: We are happy to confirm that the Cascade system to integrate the process of notification of neonatal deaths (babies born alive who die within 28 days) to MBRRACE-UK and CDOPs in England, making this a single activity, is now live. This step forward represents a huge amount of work, and you can find our latest guidance on the new System: Cascade Integrated System

Statutory data collection form updates: There will be several changes released to the epilepsy supplementary reporting form in February 2025, as a result of MHRA guidance changes in relation to the prescription of Sodium Valproate. In addition, a small number of changes will be applied to some questions from 1 April 2025. There will be a further communication on these changes to CDOPs in due course.

From 1 April 2025, updates to statutory data collection forms, including any additional questions, will only occur on an annual basis. This is to provide stability to data collection and forms. CDOPs and CDR professionals should continue to submit suggestions for requests to update questions to ncmd-programme@bristol.ac.uk, but please note that these will only be reviewed on an annual basis going forward.

Suffolk Child Death Review Team

Annual Study Day

Wednesday 15th October 2025

Open to all professionals interested in child death processes and policies.

Day will include a detailed look at various cases nurses have worked on from different points of view, including the parent's perspective.

Guest speakers will also be presenting.

More details to follow- lunch provided.

Save The Date - Learning From Child Deaths In Suffolk

This year we are holding our annual learning event on the 15th of October 2025 at Kesgrave War Memorial Community Centre.

Our team would love to hear from you!

Please do send us any suggestions for the learning event this year of what you would like to be included.

Please also do get in contact if you would like to be a speaker at the event or have any recommended speakers you would like to share with us. Our contact details can be found on the front page of this newsletter