ISSUE NO.6 SEPTEMBER 2023

Norfolk and Waveney Integrated Care Board

NEWSLETTER

CHILD DEATH REVIEW TEAM

CONTACT INFORMATION: **Team phone number: 01603 257160 (please update your records)**

nwicb.childdeathreviewteam@nhs.net

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

Working times: 08:00-18:00 Monday to Friday

If you are notifying us of a child death, please use the eCDOP reporting site to complete a Form A at: https://www.ecdop.co.uk/NorfolkSuffolk/Live/Public

Ready to Change

Norfolk County Council has developed a free tool using behaviour change science called 'Ready to Change'. The tool aims to help individuals reducing alcohol intake and develop healthy habits.

Link to help to drink less

Sadly alcohol can be a modifiable factor in cases of child death and it is important to offer parents including pregnant mothers and those thinking about Pregnancy, advice and information about how to make positive changes.

ROSPA; National learning from a Norfolk child death

Changes in national safety advice about cables around cots and ensuring parents follow the advice.

ROSPA accidents don't have to happen

https://www.rospa.com/resources

NHS
Norfolk and Waveney
Integrated Care Board

CHILD DEATH REVIEW TEAM

Sudden unexpected death in epilepsy

Each year in the UK roughly 600 people with epilepsy will die suddenly with no obvious cause. This is called sudden unexpected death in epilepsy, or SUDEP. The rates of SUDEP in children (under18's), are much lower. This risk rises with more complex types of epilepsy, e.g., Dravet Syndrome. While the numbers in children are lower, it is not something that should be ignored. The death of any child is a tragedy and families desperately want to know what has happened, how the event could have occurred, and whether it could have been prevented. **SUDEP is not well understood.**

Over the past year there were two SUDEP's in Norfolk. Both children were aged 17 years and on the days that each of them had died they had been seemingly well.

The child death review team coordinate the statutory multi-agency protocol that respond to and investigate factors that may have contributed to the death. Following rigorous scrutiny each case is taken to the Child Death Overview Panel. The multi-agency panel, set up by child death review partners, hear each case to learn lessons for the prevention of future child deaths. The outcome therefore is to identify both local and national learning. The child death overview panel report is uploaded into the National child mortality database. www.ncmd.info

In the cases previously mentioned children, both families had been made aware of the risk of sudden death, one more so as the father had previously lost his wife to SUDEP. This case demonstrates an absolute need for professionals to have an awareness and to be fully informed of ways to reduce risk, exposure and minimising the likelihood of an incident. We are aware that we cannot mitigate all risks, however having conversations and being able to direct families to resources is an extra layer of education, and in addition to managing seizure first aid.

For children who are at risk of seizures consideration of the living environment is an important discussion to have with their family. For example, in a cramped bedroom is there space around the bed to access a child having a seizure. If not, is there a double bed that could be changed for a single bed. This would facilitate better ease of access should a seizure occur. If the child is known to be experiencing regular break through seizures and the sleeping space is cramped, does there need to be a bedframe? If the child is found seizing in a cramped space, it would be easier to assist the child into the recovery position onto a mattress on the floor rather than struggling to gain access to them to secure the airway. These are the conversations that may have prevented the death of a young adult.
There is an excellent website that provides research, education, resources for professional with training videos. This can be found at SUDEP action. – sudep.org. http://sudep.org/

Resources:

http://sudep.org/
http://epilepsysociety.org.uk
www.nice.org.uk Epilepsies in children, young people, and adults. NICE guideline [NG217] Published: 27 April 2022. (chapter 10).

NHS
Norfolk and Waveney
Integrated Care Board

CHILD DEATH REVIEW TEAM

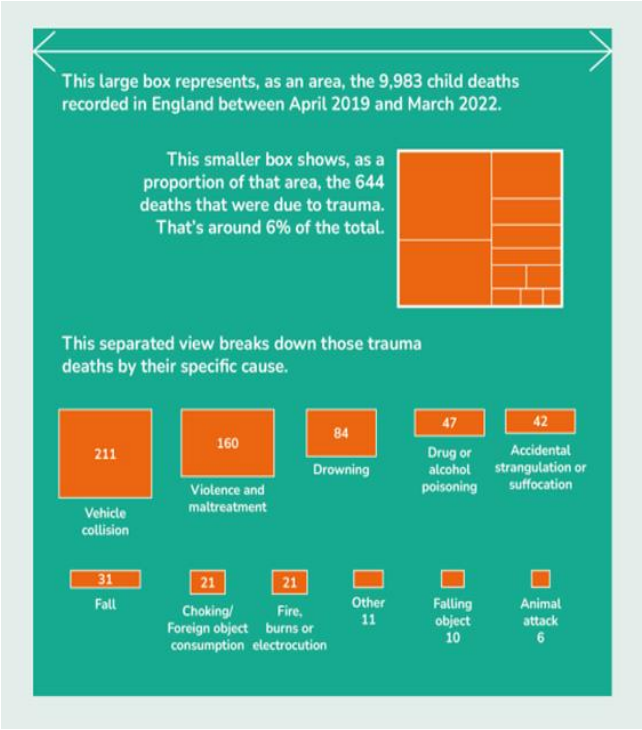
Deaths of children and young people due to traumatic incidents

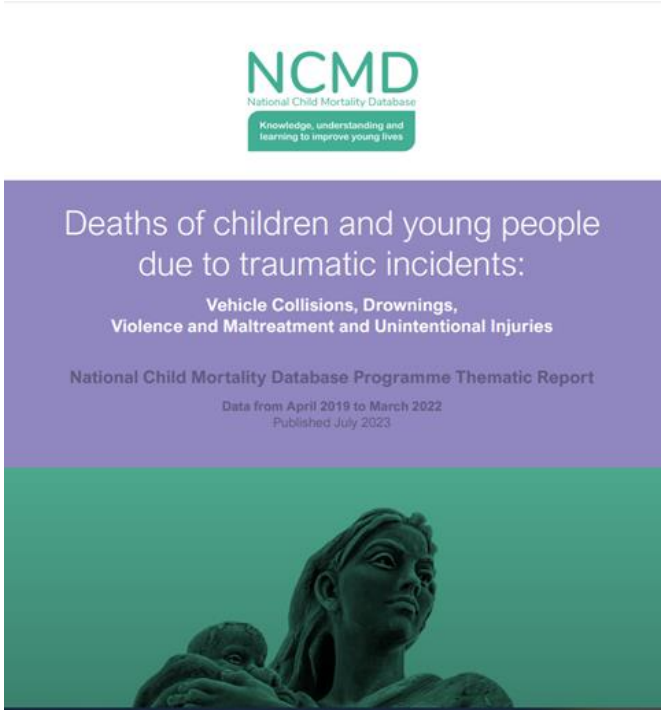
The NCMD published a thematic review July 2023: Link to full report: LINK TO FULL REPORT
The report uses data collected from a three-year period (April 2019 to March 2022). It analyses child deaths due to a physical trauma. The were 644 deaths of children due to physical trauma in this time period. Road traffic collisions, violence and maltreatment, drowning and other traumatic injuries.

Death from vehicle collision was most common category of death, followed by risk of death from violence and maltreatment, followed by drowning. Death rate was higher in children under 5 years and children aged 15-17 years. Death rate higher for males than females. Deaths rate for children living in the most deprived neighbourhoods was more than twice that in the least deprived neighbourhood (NCMD, 2023).

The report makes 18 recommendations including:

Road safety education for all primary school children.
Prioritise measures to safeguard and protect children under one from non-accidental injuries using recommendations from 'the myth of invisible men'
Safe bathing techniques; adults always staying within arm's reach of young children at bath time.
Targeted water safety education for those children unable to access private or statutory swimming, tuition.
Drug and alcohol education in school for all children and young people between ages of 10-18 years.
Raise aware ness of PTSD among health care professionals and complex grief and how these may affect families whose child has died of a traumatic incident.
Improve information sharing and communication between local authorities and agencies where children move between areas.





NHS
Norfolk and Waveney
Integrated Care Board

CHILD DEATH REVIEW TEAM

Resources for families and professionals:

Lullaby Trust:

This is a new resource produced by the lullaby trust. It provides tips for families coping with the trauma of a sudden bereavement of a child. It includes how the bereavement may make a person feel and what may help.

LINK TO RESOURCE

Child Death Helpline:

LINK TO WEBSITE

Child Death HELPLINE
We're here to listen

A freephone service for all those affected by the death of a child

Our confidential helpline is open every day of the year.

Monday to Sunday
19:00 to 22:00

Monday, Thursday and Friday
10:00 to 13:00

Tuesday and Wednesday
10:00 to 16:00

Call our freephone helpline on 0800 282 986.

Care for the Family is a national charity, they have a telephone befriending service, events for bereaved parents.

https://createsend.com/t/r-CCE1BAE337DF2FDC2540EF23F30FEDED

Care for the Family

And finally, we wish Julia Fothergill, one of our Deputy Child Death Review Nurses, a very happy retirement from the 6th October and hope she enjoys the rest and the allotment!

We will miss you Julia

xxx