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CDOP Newsletter

Luton Safeguarding Children Board

Bedford Borough Safeguarding Children Board

Central Bedfordshire Safeguarding Children Board

The death of a child is a tragedy, it is vital to review all child deaths so that we can learn as much as possible from them to enable us to support families and try to prevent future deaths. The Child Death Overview Panel (CDOP) became a statutory function in 2008 & meets up to 9 times per year. All deaths are discussed anonymously at a CDOP panel. The panel consists of representatives from the 3 Local Safeguarding Children Boards across Bedfordshire & Luton including health, public health, the police, ambulance, social care, LSCB Business Managers & a lay member.

Serious Case Reviews (SCRs) child D:

Luton LSCB have recently published the findings from a serious case review into the death of a Baby. The father has been found guilty of manslaughter and jailed for 7 years. It was found that he had shaken his baby with excessive force.

The learning from this case has been published on the LSCB website, one of the lessons for professionals is to investigate and report to social care bruises on immobile babies.

Many parents contact health professionals asking about support for crying babies and the NSPCC have published an information leaflet for parents, https://www.nspcc.org.uk/globalassets/documents/advice-and-info/handle-with-care-guide-keeping-baby-safe.pdf

further copies can be purchased from the NSPCC

Asthma

One in 11 children has asthma and it is the most common long-term medical condition.

• On average there are two children with asthma in every classroom in the UK.

• The UK has among the highest prevalence rates of asthma symptoms in children worldwide.

• There were 25,073 emergency hospital admissions for children in the UK in 2011-2012. That means on average there were 69 per day, or one every 21 minutes for asthma.

Tragically there were 1,167 deaths from asthma in the UK in 2011 (18 of these were children aged 14 and under)

Asthma UK commissioned a review into asthma deaths in 2014 and found the following

Overall quality of care •

The National Review found that 46% of deaths could have been avoided if patients had been better managed in the year before they died. Several aspects of care were well below the expected standard for 26% of people of all ages, and 46% of children and young people.

Prescribing • When people's asthma is well controlled, they should have little or no need for their reliever inhaler. The National Review says that anyone who has been given more than 12 reliever inhalers in a year should be **urgently** called in for review and may need a preventer inhaler. The National Review had prescribing data on reliever inhalers for 165 people. Thirty nine percent had been prescribed more than 12 reliever inhalers in the year before they died. Four per cent had been prescribed more than 50 inhalers. • Preventer inhalers should be taken daily - in order to follow their doctor's advice, people who have been prescribed preventer inhalers would normally need at least 12 of them a year.

What can you do?

Ensure children with asthma receive regular asthma checkups with their GP/Practice Nurse and that the child knows how to correctly use their inhalers.

Staff in schools should receive training on how to manage children with asthma.

Ensure children have a personal asthma action plan card – these can be downloaded from Asthma UK by parents free of charge.

If you become aware of children using a large number of reliever inhalers, make sure that they are reviewed by their GP or practice nurse.

Asthma UK has some fantastic resources that professionals can access and direct families to. http://www.asthma.org.uk/resources#EasyReadDownloads

Healthy Lifestyles

A healthy lifestyle helps to protect families from premature death. Across the UK some of the risks and factors classed as modifiable (factors which changed could improve the outcome, something that can be changed) identified by the CDOP panel are smoking, alcohol/substance misuse and obesity. Tackling these before or early in pregnancy reduces risks associated with premature birth, and neonatal deaths. Across the UK 33% of the child deaths reviewed were due to a perinatal / neonatal event. It is documented that the following factors can lead to premature labour:

Smoking when pregnant increases the risk of:

- miscarriage
- ectopic pregnancy (a pregnancy growing outside the womb)
- a baby dying in the womb (stillbirth) or shortly after birth – one third of all deaths in the womb or shortly after birth are thought to be caused by smoking
- babies being born with abnormalities – face defects, such as cleft lip and palate are more common because smoking affects the way a baby develops
- bleeding during the last months of pregnancy, which is known as an abruption (when the placenta comes away from the wall of the womb) – this could be life threatening for mother and baby
- premature birth, when baby is born before 37 weeks of pregnancy.

Obesity: women with a BMI over 30 are at increased risks during pregnancy. Including miscarriage, gestational diabetes, high blood pressure, pre eclampsia, blood clots and are more likely to need an instrumental delivery (such as ventouse or forceps).

Families can contact their GP, Health Visitor or Midwife for advise and support to quit smoking, lose weight or adopting a healthier lifestyles.

Button Batteries

Many toys have button batteries, these can be attractive to young children, and having an inquisitive nature some children put them in their mouth. Although a child may not choke, if undetected the batteries can do serious damage to the gastrointestinal system. When combined with saliva, the electrical current from the battery produces caustic soda that burns through the throat or stomach and can cause further damage to other internal organs.

Reducing the risks

Some products (predominantly toys) have lockable battery compartments and these should mean that they are safe for children to use. Other products such as musical greeting cards, flameless candles and remote controls do not have lockable compartments, and so parents need to be extra vigilant with these products.

RoSPA advises that children should not be allowed to have access to these products if the battery compartment is not secure. Also, it is a very good idea to ensure that spare batteries are locked away, and used batteries are disposed of correctly

Reporting a Child Death

If you are aware of the death of a child under the age of 18 please ensure that the CDOP manager is informed as soon as possible after the death and complete a Data Collection Form A which can be found on the Local LSCB websites: email to bedfordshire-cdopmanager@nhs.net or call on 01525 864430 ext 5878:

Ongoing safety issues being reviewed by other CDOP's:

- **Drowning following unsupervised use of baby and toddler bath seats.**
- **Risk of suffocation from nappy sacks**
- **Unsecured or wrongly fitted large TV's**
- **Ingestion of liquid tabs**
- **Suffocation due to unsafe sleeping arrangements and certain types of baby sling**

For further information check
http://www.capt.org.uk/safety-advice