# WILTSHIRE AND SWINDON CHILD DEATH OVERVIEW PANEL (CDOP) NEWSLETTER

**September Edition**
**2021**

The Wiltshire and Swindon Child Death Overview Panel (CDOP) review every child death, to identify any modifiable factors which may have contributed to the death, and what, if any, action could be taken to prevent future deaths.

This newsletter is for professionals working with parents and their children, to highlight some of the learning, guidance, and useful resources to support safe, healthy families.

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## Child Death Reporting Forms – Timeliness and Quality

There have been some recent issues with the timeliness and quality of the completion of forms required as part of the child death process. This has meant that for some cases, CDOP was not able to review the information for some time after the child death and was therefore not able to identify timely actions to prevent further deaths occurring. An example of this is an information field requested, but often left incomplete, 'Ethnicity and Gestational Age at Birth'.

Please ensure you follow the protocol and comply with timescales outlined as far as possible by:

- All Reporting Forms (Form Bs) to be returned to the CDOP office within **three months of death** by secure transfer.
- The Local Child Death Review (CDR) meeting should take place within **6 months of death** unless a postmortem is required.
- Reporting forms should be sent to the chair of CDR meeting **one week beforehand.**

- Child Death Review Analysis forms should be completed by the chair of the CDR meetings and sent to the CDOP office. The CDOP office will compile anonymous case records from Notification and Reporting forms and Child Death Review Analysis forms for presentation to the CDOP panel.

For full information on the protocol please click the link below:
Wiltshire and Swindon JAR and Child Death Protocol for Unexpected Deaths | Swindon Borough Council

The National Child Mortality Database (NCMD) programme offers advice and training on how to complete Notification forms, Reporting forms and provides guidance on Child Death Review Meetings.

Free webinars are available here. You can request copies of the webinars to view at a convenient time for you via this link and by selecting Analysis Forms on the menu on the right-hand side of the screen.

**'How to complete an effective reporting form' webinar takes place on Tuesday 21st September between 10:30am - 11:30am.** This is a free webinar for Child Death Review professionals on how to complete an effective reporting form. This webinar will include a presentation from NCMD Programme Manager, Vicky Sleap and is aimed at CDOP managers, administrators, designated doctors and other child death review professionals. It will include the purpose of the reporting form, types of reporting forms, what to include and what happens to the information you provide. If you have a question on completing a reporting form that you would like to submit in advance of this webinar, please send it to childhealth@uclpartners.com by Friday 17th September 2021. Register here: https://us02web.zoom.us/webinar/register/WN_8Ltu_udeTwiMPk3BEpudcw

We would also encourage professionals to stay up to date by signing up to the mailing list for the newsletter here.

## National Child Mortality Database Report (2019/20)

The National Child Mortality Database published a recent report in May 2021 based on data on children who died in England between April 2019 and March 2020. An overview of the key findings is shown below:

- The report demonstrated a clear association between the risk of death and level of deprivation for children who died in this time period.
  This association appeared to exist for all categories of death except malignancy.
- On average, there was a relative 10% increase in risk of death between each decile of increasing deprivation.
- Over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived. This translates to over 700 fewer children dying per year.
- The proportion of deaths with identified modifiable contributory factors increased with increasing deprivation; with factors relating to the social environment being the most frequently reported.
- At least 1 in 12 of all child deaths reviewed in 2019/20 had one or more factors related to deprivation identified at review.
- There were exemplar projects highlighting how CDOPs had developed local strategies, informed by recurring review themes and local learning, to reduce infant mortality.

To read the full report click here.

## Listeria Risks in Pregnancy

Following a recent case review conducted by CDOP where there were complications present due to Listeria, CDOP reminds practitioners how crucial it is to ensure to highlight with women, their partners and close family that certain foods should be avoided during pregnancy, as they can put the mother and/or unborn baby at risk.

This includes:

- Foods that may contain Listeria due to associated risks which can lead to miscarriage stillbirth or serious sickness in newborn infants.
- Foods that may contain Salmonella which can cause serious illness in mothers
- Foods containing high levels of vitamin A, in particular liver and other liver products
- Fish that contains high levels of methylmercury. Exposure to high levels of methylmercury in the womb can affect the nervous system of the fetus, potentially increasing the risk of learning or behavioural problems.
- Tuna - no more than four medium-sized cans or two fresh tuna steaks per week as they may also contain high levels of mercury.
- Caffeine should be limited to 200mg a day — high levels of caffeine have been associated with low birth weight in babies. Caffeine is present in coffee, tea, chocolate, and some soft drinks.

Full NICE guidance is available below:

- NICE - Antenatal care

## Premature rupture of membranes/fluid leakage in pregnancy

CDOP recently reviewed a case of a woman who had experienced fluid leakage during her pregnancy for a week before being identified during a routine appointment.

This case identified the need to highlight the importance of informing women to seek help for potential Premature Rupture of Membranes (PROM) in pregnancy, particularly for high-risk pregnancies.

Clear patient information is available to women on the Baby Centre website:

- Leaking Amniotic Fluid: Premature Rupture of Membranes | BabyCenter

## Safe Sleeping

**Pods and Nests**

Following CDOP discussion on co-sleeping advice following some recent deaths, the panel highlights the importance of ensuring safe sleeping guidance is provided to and understood by new parents.

A huge number of products are available to new parents and it is vital to support understanding and reduce confusion around choosing baby products.

Popular products including sleeping pods, nests, hammocks, cot bumpers and others such as these that do not conform to safer sleep advice may pose a risk to babies under 12 months old.
Guidance in relation to products like these is available on The Lullaby Trust website:

- Product Guide: a guide to buying safer sleep essentials.

Guidance on reducing the risk of SIDS is available on the NHS website:

- Reducing the risk of sudden infant death syndrome (SIDS).

**Co-Sleeping**

it is important to know that there are times when co-sleeping can be very dangerous and should be avoided. Practitioners should ensure that new parents are aware and understand not to co-sleep if any of the following apply:

- Either parent smokes (even if this is not in the bedroom)
- Either parent has drunk alcohol or taken drugs (this includes any medication that may cause drowsiness)
- The baby was born premature (before 37 weeks)
- The baby was born at a low weight (2.5kg or 51/2lbs or less)
- Never sleep on a sofa or armchair with the baby - this can increase the risk of SIDs by 50 times

Some parents do choose to bed share with their babies, please see the useful link from The Lullaby Trust below advising on how to co-sleep more safely.

- YouTube: Lullaby Trust - How to co-sleep more safely.

A National review into sudden unexpected death in infancy (SUDI) in families where children are considered at risk of significant harm sets out recommendations and findings for government and local safeguarding partners to better protect infants from SUDI which professionals may find useful to access.

## Gestation time and signs of life in extreme prematurity and implications

New clinical guidance has been published to support health professionals in the assessment and documentation of signs of life in significantly preterm births. It advises on support that should be provided and that practitioners should be aware and made available to parents irrespective of whether their baby is born showing signs of life.

This new guidance has implications for bereavement leave for parents which is outlined in recent updates made by Acas: Working for everyone in relation to parental bereavement leave and pay when a child dies, if death is under the age of 18 or if a baby is stillborn after 24 weeks of pregnancy.

The full clinical guidance from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) is available here

For a full overview of conditions and rights for eligible parents in the guidance, the Acas: Working for Everyone guidance is available here.

For more information about CDOP or if you have any suggestions for future editions of the Wiltshire and Swindon CDOP newsletter, please email: publichealth@swindon.gov.uk.

The CDOP newsletter will be produced twice a year.

Wiltshire Safeguarding Vulnerable People Partnership

Swindon Safeguarding Partnership