CDOP Newsletter

Bradford BSCB Safeguarding Children Board

March 2018

Child Death Overview Panel

CDOP ANNUAL REPORT

The CDOP Annual report 2016-2017 is now available on the BSCB website. This provides key information of data collection and analysis over the past 9 years highlighting areas of work undertaken by the CDOP.
http://bradfordscb.org.uk/?page_id=138

TEACHING SESSION

Further sessions are being planned for 2018 to deliver multi-agency, multi-professional training around the SUDIC and CDOP processes. These sessions are aimed at informing staff of the statutory requirements around CDOP, the Rapid Response, data collection, Phase I meetings etc. The next session is Monday 5th March and further sessions are being planned for throughout 2018.

SIDS & CO-SLEEPING

Over the years the district have continued to see babies under a year of age who have died due to Sudden Infant Death Syndrome (SIDS). In the majority of cases it has occurred alongside co-sleeping in bed with risk factors such as smoking, alcohol or drug use or sometimes sleeping on a sofa. We wanted to share the finding of the Child Death Overview Panel (CDOP), which reviews every child death under 18 years to identify modifiable causes.

As there is an association between SIDS and co-sleeping, especially when risk factors are present, we identify such infants deaths to be modifiable. It remains one of our key recurrent causes of modifiable deaths.

Bradford CDOP is asking for your organization to help minimize the chances of similar deaths in the future by ensuring this issue continues to be a high priority.

Please ensure all your staff are fully aware of current policies and guidance and are able to communicate the risks effectively with parents and families.

Reporting a Child Death

All deaths of children from birth to the day before their 18th birthday should be reported through the Child Death Review Office as soon as possible after death. It is important to remember that a child's death should be reviewed in the area where the child would normally reside rather than in the area which they die.

Please Notify: Louise Clarkson CDOP Manager on 01274 383519. Notification forms can also be found on the BSCB website.

SAFER SLEEP WEEK

Lullaby Trust annual awareness campaign, Safer Sleep Week runs 12th—18th March 2018.

Aimed to raise awareness of SIDS to reach as many parents as possible,

Display packs are available on: https://www.lullabytrust.org.uk/product/safer-sleep-week-display-pack

Useful Links to Video on Safe sleep and leaf-let –both for parents

https://www.lullabytrust.org.uk/safer-sleep -advice/

https://www.lullabytrust.org.uk/wp-content/uploads/safer-sleep-for-parents.pdf

Professionals are asked to provide Safer Sleep on social media at 10am on Monday 12 March and all week using the official campaign hashtag #safersleepweek

CDOP has noted previously that the NICE guidance on postnatal care was updated in December 2014 (Clinical Guideline CG37)and included an update on co-sleeping :

The NICE recommendations on co-sleeping and SIDS cover the first year of an infant's life.

- Recognise that co-sleeping can be intentional and unintentional. Discuss this with parents and carers and inform them that there is an association between co-sleeping (parents or carers sleeping on a bed or sofa or chair with an infant) and SIDS [new 2014]
- Inform parents and carers that the association between co-sleeping (sleeping on a bed or sofa or chair with an infant) and SIDS is likely to be greater when they, or their partner smoke [new 2014]
- Inform parents and carers that the association between co-sleeping (sleeping on a bed or sofa or chair with an infant) and SIDS may be greater with:
    - Parental or carers recent alcohol consumption or
    - Parental or carers drug use, or
    - Low birth weight or premature infants (new 2014)

NAPPY SACKS & FOREIGN BODIES

Choking and suffocation risk to babies from nappy sacks

Nappy sacks have been implicated in causing suffocation and choking of babies less than one year old. In September 2010 the death of a local baby due to asphyxia from nappy sack was brought to the attention of the Child Accident Prevention Co-ordinator for NHS Cornwall via their local Safeguarding Children Board.

Further investigation nationally highlighted that fact asphyxia from nappy sacks had caused up to 10 known deaths in babies across England and Wales alone. However, none of these cases had come to the attention of the national accident prevention bodies, nor had they been logged on the National Trading Standards database. Each area had assumed their incidents were one off and isolated cases.

Why is this happening?

The typical scenario associated with the deaths is that the sacks are stored within the baby's reach, close to the baby's cot—including under the mattress usually for convenience. In some cases, the nappy sacks had been left near to or in the cot for ease of changing the baby's nappy in the night. The light flimsy material of the bag is easy for a baby to grasp automatically and then instinctively bring to their mouth for exploration, which can lead to obstruction of the nose and mouth and even inhalation.

Feedback from parents, carers and professionals demonstrated that the risk to young babies is compounded by the fact that widespread usage of nappy sacks is a relatively recent phenomenon. Parents and carers are generally aware of the dangers posed by plastic bags, but do not make the same link to nappy sacks and so are less likely to take the same safety precautions. The risk of potential hazard is increased by the lack of mandatory suffocation warning advice on the packaging and the product's frequent availability as loose bags in a packet, as opposed to supplied on a roll.

Inhalation of foreign objects

Over the past 9 years CDOP have seen a small num-ber of cases due to inhalation of foreign objects.

Toddlers and infants often explore and learn about items by putting them in their mouths. A child's risk of swallowing something potentially dangerous increases when they are left with little or no supervision. The risk also increases when the following types of objects are within reach:

- Coins
- Small batteries
- Buttons
- Marbles
- Rocks
- Nails
- Screws
- Pins
- Small magnets

The symptoms of a swallowed foreign object are usually hard to miss. Symptoms are immediate if the object blocks the airway. The most common being:

- Choking
- Difficulty in breathing
- Cough
- Wheezing

Possible symptoms that occur when an item is stuck in the oesophagus or bowel include:

- Vomiting
- Drooling
- Gagging
- Chest or throat pain
- Refusal to eat
- Abdominal pain
- Fever

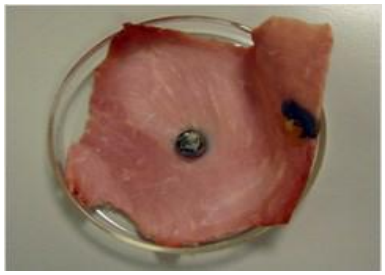
It is important that medical attention is sought if a child swallows a foreign object. Swallowing a magnetic object is a medical emergency and medical attention should be sought immediately.

Button batteries pose a deadly risk to toddlers.

Lithium batteries react with saliva so that they leak acid within as little as an hour. If a child swallows a battery it can cause severe trauma, such as burning a hole in their throat or stomach or further damage to other internal organs or even death.

As the tiny batteries become more popular and more powerful, doctors are seeing an increase in serious injuries and fatalities from swallowing incidents. The batteries, most measuring about 20 millimeters, can be found in everything from remotes to toys to singing greeting cards and other home electronics. Children have mistaken them for sweets and adults for tablets with disturbing results.

The risk posed by a "button battery" when it's swallowed is not choking but that the moist lining of the gastrointestinal tract acts as a conductor and allows current to flow through the battery causing internal burns. The longer the battery remains in the body, the more severe the burns can become—lasting damage can occur within just two hours.



Simulation of a button battery ingestion with a piece of meat.

Further information regarding safety can be found at:

https://www.rospa.com/