CDOP NEWSLETTER

FOR PRACTITIONERS

DECEMBER 2024

Items for the newsletter are gathered from learning identified whilst reviewing cases at CDOP

Inside this issue: *Safer sleep during winter and Christmas travel, toy safety at Christmas, best practice guides, National CDR Data update.*

Plan ahead for sleep away from home

Families will be travelling and staying away from home over the Christmas period. It is important that they are reminded to plan ahead and consider where their baby will sleep, whilst following safer sleep guidelines.

Ideally a cot or moses basket would be available for baby to sleep in. However, if not, some prams are suitable as a sleep space:

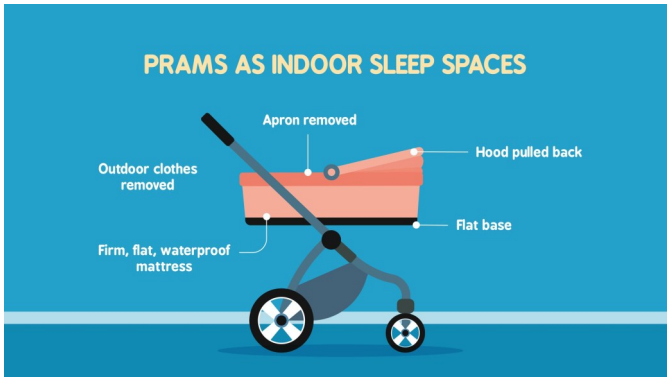
- Is it completely flat:
- Is the mattress firm and waterproof with no cushioned or raised edges?
- Can the pram hood be pulled back?
- Can the apron be removed?

Be aware that they can trap more heat than a cot, so adjust the baby's bedding accordingly.

If parents are considering co sleeping please discuss with them and remember to utilise the co-sleeping checklist. Parents should not co-sleep if:

- Baby was born prematurely or with a low birth weight.
- If either adult smokes or has drank alcohol.
- If they've taken medication that makes them sleepy or if they are extremely tired.

Remind parents that pods, bouncers, swings, sofas or car seats are **NOT** safe places for a baby to sleep.



Safer sleep in winter

The colder months can be difficult for families, particularly with the rising cost of living and there is some concern how it might impact on families being able to follow safer sleep advice.

Families may be worried about keeping their babies warm if they cannot afford to heat their homes. This may lead to them overwrapping their baby, causing them to overheat, which is a significant risk factor for SIDS.

The Lullaby Trust **"Safer Sleep in Winter"** resource offers advice on safer sleep during the colder months. Families can be signposted to financial support services such as the national debt line or Stepchange.

The Lullaby Trust have also created "Safer sleep advice for emergency situations" in recognition that following a safer sleep routine can be difficult for families fleeing conflict or crisis. This resource includes important advice for different sleeping situations, taking into account that some families may not have an ideal sleeping place for their baby.

- **Ask families if they are worried about keeping their baby warm at home.**
- **Be aware of home environments, temperature and safe sleeping arrangements.**
- **See where baby sleeps day and night**
- **Discuss co-sleeping and complete the checklist.**

Toy Safety this Christmas. SHOP SMART & STAY SAFE

Many assume that if a toy is available to buy, then it must be safe. But sadly, there are an increasing amount of unsafe toys available to buy online. The appeal of cheap toys could have fatal consequences. Many cheap toys from unknown sellers online come from abroad & have not been safety checked. CAPT Toy Safety poster and resources.

Button Batteries

Button batteries can badly harm or kill a child if swallowed. If it gets stuck, the battery can burn through the food pipe, to the main artery and lead to catastrophic internal bleeding. This video shows the harm they can cause. Watch out for easily accessible button batteries in light-up decorations, singing toys, flashing wands. Free button battery resources.

Look

Look around your home for button batteries. Think toys, lights, remote controls and more.

Check

Check for products with loose backs and button batteries that have dropped out.

Store

Store button batteries in a safe place, up high and out of your child's reach.

Dispose

Dispose of used button batteries as soon as you can. They are still unsafe. Learn why.

Act

If you think your child may have swallowed a button battery, go straight to A&E or call an

Water beads

With their bright colours and squishy feel, water beads are really appealing to young children, but can be extremely dangerous if swallowed. They can expand in fluid 400 times their original size to that of a golf ball, causing blockages in a child's bowel. They can also be inhaled and therefore a choking hazard. The beads don't show on x-ray so it can be complicated to locate them and it is highly likely that a child will need major surgery if swallowed. They are easily bought online and most come with no visible warnings about the dangers they pose. There is an **URGENT ALERT** to keep water beads away from children under the age of 5. Water bead resources.

5 top tips for buying safe toys online

Take care when shopping at marketplaces online (think AliExpress, Amazon, eBay, Etsy, Groupon, Joom, OnBuy, Shein, Temu, TikTok Shop and Wish). There might be dangerous products that haven't been safety checked.

Buy toys from brand names you know. If you've never heard of the seller and the price is really tempting, the toy could be dangerous.

Be really careful when buying for under 3s as they're most at risk from dangerous toys.

Watch out for cheap copies of popular toys. They may not be made to UK safety standards.

Check if the toy has been removed from sale because it's unsafe. Visit gov.uk for a list of recalled products.

If you buy something that looks unsafe, trust your instincts and send it back.

Magnetic toys

If swallowed, high-strength magnets can rip through a child's gut causing serious and life-threatening injuries. Some of the cheaper toys sold by unknown sellers online are often much stronger and may not come with safety warnings. They can be found in jewelry-making kits, building kits, fridge magnets, etc. Teach older children about the risks of putting magnets in or near their mouths and keep away from younger children. Magnet safety resource.

Under 3s at biggest risk

Babies and toddlers are curious and naturally put everything in their mouths so they are at risk of:

- Swallowing button batteries
- Swallowing magnets
- Swallowing potentially harmful chemicals
- Choking on toys with small parts or long fur or hair

Plus, their windpipes are smaller and softer than those of adults and older children, so they can suffocate far more quickly if they get tangled up in long cords.

That's why, if you're shopping for a child under 3, we recommend opting for well-known brand names and retailers if you can.

Unsafe sleep products

Be aware and raise awareness of unsafe sleep products available online. Such as hug pillows, sleeping bags, feeding pillows, etc. Parents assume that because it's available online to buy, that they must be safe. This is further strengthened if products are expensive. Lullaby trust do not recommend use of pillows. Sleep bags should be well fitted with no hoods or head coverings. A baby needs their caregiver to feed them their bottle so that they can react if baby starts gagging or choking. Any product that encourages parents to leave their baby to feed on their own, are not recommended.

Best Practice Guides

In 2023, DDSCP undertook two Rapid Reviews about two unconnected children who were suspected to have died as a result of abuse or neglect. Child in Need arrangements was an overarching learning area across both cases. Special Guardianship Orders and Personal Health Budgets were identified as individual learning areas.

DDSCP therefore produced 3 best practice guides to support practitioners working with children and families **where child in need plans, personal health budgets** or **special guardianship orders** are a feature.

The best practice guides provide a framework for practitioners working collaboratively across all agencies to help improve outcomes for children and their families in the areas of assessment, planning, intervention, review and evaluation and exit planning.

NCMD Data Release 2024

The National Child Mortality Database (NCMD) collates data collected by Child Death Overview Panels (CDOPs) in England, from reviews of all children who die at any time after birth and before their 18th birthday. This is crucial to identify learning and to prevent future deaths. There is a statutory requirement for CDOPs to collect these data and to provide them to NCMD, as outlined in the Child Death Review statutory and operational guidance. It is therefore vital that CDOP are notified of all child deaths and that the information provided is accurate and completed fully.

For children who normally reside in Derby City or Derbyshire you need to submit a notification via this link: **https://www.ecdop.co.uk/Derbyshire/Live/Public**

The guidance requires all CDOP to gather information from every agency that has had contact with the child, during their life and after their death, including health and social care services, law enforcement, and education services. This is done via a secure electronic portal (eCDOP).

Every child who dies is a precious individual and their deaths represent a devastating loss for parents, siblings, grandparents, carers, guardians, extended family and friends. With all child deaths there is a strong need to understand what happened, and why. We must ensure that anything that can be learned to prevent future deaths from happening is identified and acted upon. The NCMD have recently published a report to summarise information about child deaths up to 31 March 2024.

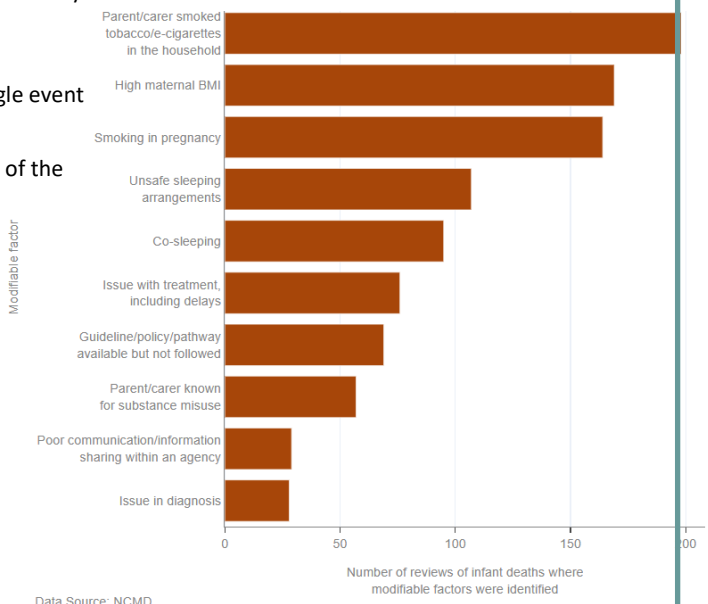
As part of the child death review process, CDOPs must record any contributory factors identified during the review and decide which of them may be modifiable.

Contributory factors are factors that either influenced or caused a single event or chain of events that contributed to the incident.

Modifiable factors are factors that may have contributed to the death of the child and that might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future deaths

The most common recorded modifiable factors by CDOPs during reviews of **infant deaths** were:

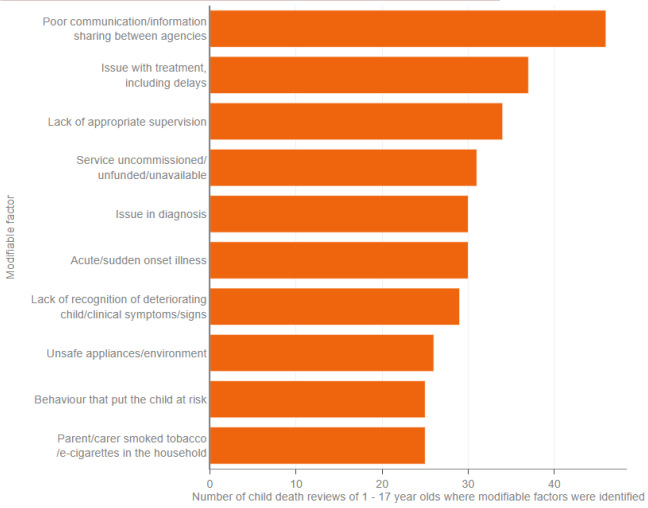
- Smoking by a parent/carer
- High maternal body mass index (BMI)
- Smoking in pregnancy



Data Source: NCMD
www.ncmd.info/cdr24/

The most common recorded modifiable factors by CDOPs during reviews of deaths of children aged **1-17 years** were:

- Poor communication between agencies
- Issues with treatment (e.g. delay in treatment, side effects/complications of treatment, or error).
- Lack of appropriate supervision (e.g. unsupervised in a bath)



Data Source: NCMD
www.ncmd.info/cdr24/

Kayleigh McMahon
Lead Nurse for Child Death Reviews in Derby & Derbyshire
kayleigh.mcmahon2@nhs.net
07584 880720

Please get in touch with any questions/queries or comments.

For eCDOP issues please contact:
CDOP Coordinator
01332 623700 ext 31540
Dhcft.cdopderbyshire@nhs.net