CDOP NEWSLETTER

FOR PRACTITIONERS

JULY 2025

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

Inside this issue: *Drowning prevention, SIDS, deprivation, bereavement*

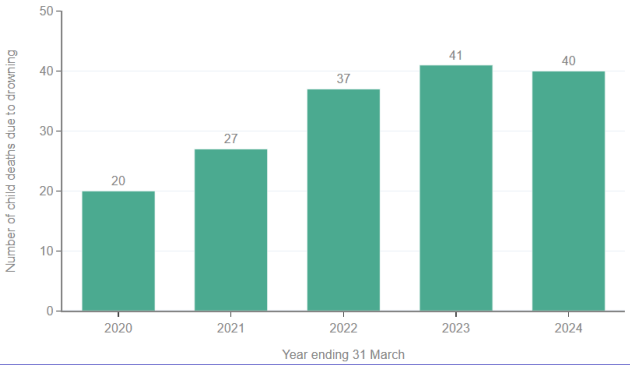
The number of children drowning in England has doubled over the last 4 years.

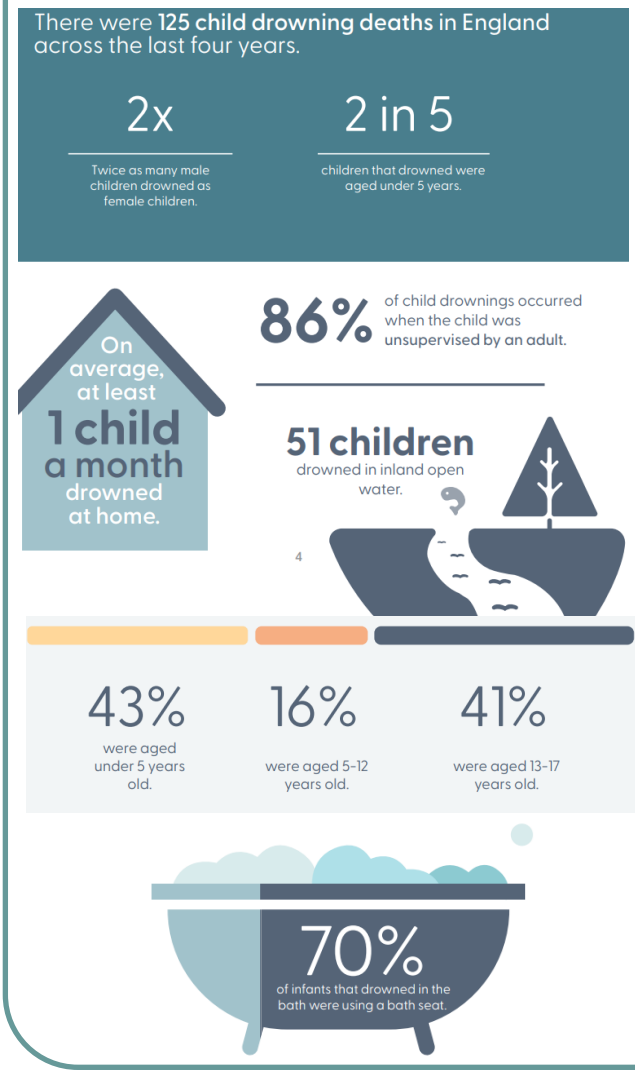
Drowning is among the 10 leading causes of death of children in every region of the World.

Drowning is consistently recognised as a highly preventable public health challenge, they are achievable, with mostly low solutions, such as installing barriers, supervision of younger children & teaching school-age children basic water safety.

Drowning deaths occur throughout the year, however the largest proportion occurred during **summer months (June/July/August)**, and therefore action is required now.

Figure 1: Number of child (0-17 years) deaths due to drowning 1 April 2019 to 31 March 2024





- **71% were male**.
- The risk of drowning was almost twice as high for children living in the **most deprived** areas.
- Children of **black ethnicity** were at 3 times higher risk than children of white ethnicity.
- 47% drowned inland (rivers/lakes)
- One child a month drowns at home in England.
- 7 in 10 parents admit to checking or using their mobile whilst their child is in the bath.
- 89% of drownings occurred where there was **no adult supervision.**
- Of the 12 infants that drowned in a bath, 67% (8) were using a **bath seat**. 72% of parents using a bath seat believe it's designed to keep a baby safe—this is not the case. A Coroner recently issued a safety warning about the use of bath seats.

DID YOU KNOW?

Drowning can happen in as little as 5cm (2 inches) of water.
Always keep young children within arm's reach.

2 in 3 children that drowned at home, did so in the bath.
This totalled 35 deaths in four years.

Reports

RLSS Child Drowning Update 2024

NCMD Deaths of Children & Young People due to traumatic incidents

NCMD child drowning deaths 2019-2024

DROWNING PREVENTION

Supervision

Ensuring appropriate supervision at all times when in, or around water, is vital. Drowning happens silently—giving a false sense of reassurance.

Babies and toddlers should be in arm's length whilst in the bath. More information on bath safety can be found on RoSPA's website, CAPT website and the NHS website.

Safety Advice

There needs to be awareness of water safety within the home, including the dangers of young in baths/hot tubs/ paddling pools etc. RLSS have recently launched the Splash Safety at your Pad Campaign., including Splash Safety in the Garden & Splash Safety in the Bath. CAPT also offer safety advice to reduce the risk of drowning.

Water Safety in Open Spaces

The Float to Live campaign reduces the chance of panic when people get into difficulty in water.

The StayWise Portal has been developed by the National Water Safety Forum & the UK's leading emergency services and safety-focused organisations. It is a free online library of educational resources for schools, youth centres & parents to help keep children safe.

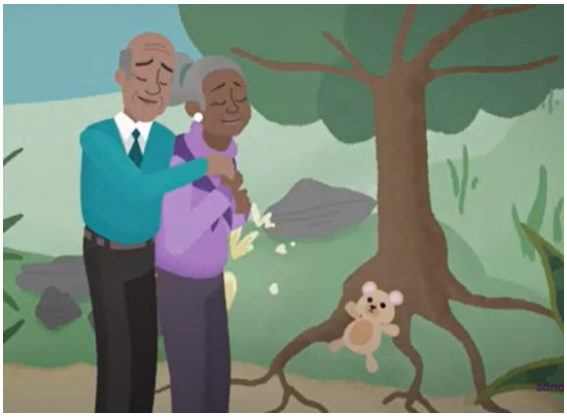
CAPT: Watch out in water
National Water Safety Forum: A future without drowning: the UK Drowning Prevention Strategy 2016-2026
RLSS: Water Safety on Holiday

Can you sit beside me on my mourning bench?

We always try to capture the voice of the child and family and feel it's important to do so.

The NCMD recently shared a blog article written by a bereaved parent (& GP). He's asked that we don't deal with the children on paper (as data) and acknowledge the child behind the words:

"Moreover, in doing so you are confronted with the reality that if this has happened to someone else, it could happen to you, to your child. No one likes to think of this, yet these conversations will likely bring you to this point. Please acknowledge this to yourself. You may need to take some time afterwards to manage any anxieties this has caused you. The path of least resistance is to note the numbers, and deal with it as 'data'. I would encourage you to connect emotionally with this. 3,577 families bereaved and grieving in one year alone. And the bereavement and grief does not stop after 12 months – it is there for good. Think on that, and when the opportunity arises, be kind, be present, try and bear witness to the pain and see if you can join with the bereaved on their mourning bench."



A journey—growing around grief animation

We all grieve in different ways; many bereaved parents describe their grief as a lifelong journey. This animation explores the journey and illustrates how, with support and understanding, bereaved families will remember their baby in their own way and find their way to live with their grief.

In the Stars animation

This animation is based on the book; a story aimed at younger children to help explore issues and questions when a baby dies.

DEPRIVATION & TEMPORARY ACCOMMODATION

A systematic review examining the relationship between social factors and early childhood health and developmental outcomes provides strong evidence that factors such as neighbourhood deprivation, lower parental income, unemployment and educational attainment, lower occupational social class, heavy physical occupational demands, lack of housing tenure and material deprivation in the household are all independently associated with a wide range of adverse health outcomes.

There are 165, 510 homeless children in England living in temporary accommodation. Many are living in dangerous conditions with little support to help navigate the complex systems. Shared Health Foundation recently shared a report reviewing children living in temporary accommodation. These deaths happened to children that, outside of temporary accommodation, would **otherwise still be alive**.

A combination of **poverty, the complexity of homelessness and deprivation** are contributing factors to the deaths of children in temporary accommodation, as well as a lack of safer sleep practices leading to sudden infant death syndrome (SIDS). 80 children that died had temporary accommodation as their main resident between Sept 23-Oct 24—this accounted for 3% of the total number of deaths.

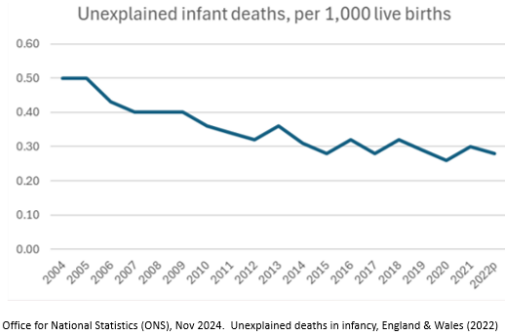
Despite the success of the "silent nightmare" campaign in 2023 which led to the homelessness code of guidance including cots/moses baskets for under 2s, there are still families living in unsuitable accommodation without safer sleep provision for their child. Currently, there is no national strategy for reducing child mortality in temporary accommodation. Without a strategic plan to tackle the impact that poverty has on child's health, we will continue to see **preventable childhood deaths**.

As a consequence of the NCMD child mortality and deprivation report (2021), information on child deprivation is now routinely gathered through the child death review process. With specific questions and guidance, it is hoped that richer data on deprivation is captured. Evidence shows that those living in the most deprived areas of England face the worst healthcare inequalities in relation to healthcare access, experience and outcomes. Examples:

1. **Crime**. *Factors related to illegal activities (direct or indirect).*
2. **Income deprivation**. *This includes low income due to people out of work, sick, retired or on maternity leave and those that are in work but who have low earnings, as well as deprivation caused by low income – rent arrears, fuel poverty, lack of heating, lighting and hot water, inadequate furniture (including inability to purchase a cot), clothes and household equipment, debts, inability to pay bills, afford transport, to afford leisure activities, food insecurity and food bank use, lack of toys, books, etc. Did the child access free school meals?*
3. **Employment deprivation**. *This includes inability to work due to unemployment, maternity, sickness or disability, or due to caring responsibilities.*
4. **Education, skills and training deprivation**. *i.e. lack of attainment and skills related to the child and / or significant others in the child's life, inability to participate in education due to lack of books, IT equipment, place to study, cost of school uniform, meals, trips, etc.*
5. **Living environment deprivation**. *Factors relating to poor housing (e.g. high rents as barriers to housing, lack of heating and /or disrepair, damp, mould, overcrowding, homelessness (including living in temporary accommodation), lack of outdoor space or play areas, no safe outside play area, or the local environment (e.g. unsafe roads or pollution levels). A home is overcrowded if 2 people have to sleep in the same room and they are: not a couple / of a different sex (children under the age of 10 do not count, they can share a room with anyone). The minimum size for a bedroom in England for a house in multiple occupation (since 2018) is: 6.51 m^2 for one person over 10 years of age. 10.22 m^2 for two persons over 10 years. 4.64 m^2 for one child under the age of 10 years. For more information and further rules that may apply see: https://england.shelter.org.uk/housing_advice/repairs/check_if_your_home_is_overcrowded_by_law.*
6. **Health deprivation & disability**. *Factors related to poor health in family members, disability or mental illness.*
7. **Barriers to services.** *Factors related to availability to local services (e.g. GP surgeries or education), or limited access to services, geographical barriers, wider barriers (i.e. affordability).*

Safer Sleep Update 2025

In 2022 there were 171 unexplained infant deaths, accounting for 7.3% of all infant deaths. The NCMD thematic report showed how infant vulnerability has increased over 30 years.



Office for National Statistics (ONS), Nov 2024. Unexplained deaths in infancy, England & Wales (2022)

Changes in Demographics & Risk Factors:

- The peak age for risk is now 1-2 months
- Low birth weight (31%) & premature (30%)
- Maternal smoking (52%)
- Neonatal admission (29%)
- Deprivation (42% most deprived vs 8% least deprived)
- Prone sleeping (40%)
- 95% co-sleeping with risk factors present
- 53% changes in routine

Why don't caregivers follow advice (Pease et al 2021):

Knowledge is different from action. Hearing advice about the risks is not always enough to influence behaviour.

External advice must be credible. Including when advice is inconsistent & conflicting. Credible sources include health professionals, friends/family/peers, internet.

Comfort, convenience & disruption to routine. Parents perceived infants as more comfortable in unsafe sleep positions. Decisions for bed-sharing were made to minimise time spent awake during the night. Disruption to routine included tiredness, being on holiday, unintentional (falling asleep on the sofa) vs intentional (just this once). Perseverance for sleep is often prioritised over maintaining a safe sleep environment.

Plausibility & mechanisms of protection. If parents knew why safe sleep practices reduced the risk, rather than just being told not to do something, they may be more likely to follow it.

Risk Mitigation. Parents develop ways to "protect" against threats to safety. For example, using bed sharing to improve monitoring of infants, using cot bumpers to prevent injury, using apnoea monitors to alert to babies in difficulty etc.

Parents experience/expertise. Conflict between parental intuition and following the rule book. Previous experience was often given as a reason to not follow safer sleep advice. "I did it when they were little & they were fine".

Keeping Babies Safe Co-Sleeping Checklist

Keeping Babies Safer Quality Conversations

Situational risks and out of routine circumstances act together to increase the risk of SUDI & may mean that families find it difficult or impossible to engage with safer sleep messages (out of routine 2020)

	1993-1996	2003-2006	2020
Median age	91 days	66 days	66 days
Death in 1st 28 days	9%	16%	26%
NICU admission	24.8%	19%	28.7%
Smoking in pregnancy	65.8%	59.5%	52.1%
Prone sleeping	37.3%	29.1%	40.4%
Co-sleeping (with risk factors)	94%	94%	95%
Changes in routine	20.6%	20.7%	52.6%
Known risks in sleep environment	-	-	72%

bmjopen-2023-076751.pdf, e000133.full.pdf, bmj.b3666.full.pdf, Bookshelf_NBK513384.pdf

Example of effective conversations about safer sleep

- **Acknowledge the good.** What is going well.
- **Check the problem being solved.** Is there a reason he's sleeping on the bean bag rather than the cot?
- **Be honest about risk & give a reason.** This would put your baby at risk.—bean bags have got straps which could pose a risk, unsafe position for airway, can get too hot etc. Babies have died in beanbags.
- **Offer practical advice**. What other (safer) options are there; cot/moses basket. Here are some ways to reduce the risk.
- **Make a safer sleep plan & offer reassurance**.

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