CHILD DEATHS / ACCIDENT PREVENTION

Safer Sleep Cascade Training for staff working in Hull

- Thursday 8th November
09:30 – 12:30 at Hull Safeguarding Children Board

Aimed at professionals working with parents before and after the birth of their baby - to inform participants about current research around safe sleeping practices to assist parents in making the best choices for themselves and their babies.

Coroner’s Regulation 28 reports to prevent future deaths (in another area)

1) Infant died following breast feeding in bed with his mother when mother fell asleep.

‘Matters of concern’ in this report - The midwives at the Hospital gave evidence that they still advise breastfeeding in bed whilst lying side-by-side with the baby even if no-one else is present and the mother is obviously fatigued, this leads to inadvertent co-sleeping and as in this case can lead to death.

Hull & East Yorkshire Breastfeeding Specialist Nurse responded to CDOP co-ordinator enquiry about local processes:

All staff would advise mothers not to take baby into her bed if she was over tired or taking medication which might sedate. Advice is given regarding safe sleep in line with the guidance and if babies are in bed in this position for breastfeeding the woman would be advised to put the baby into the cot after the feed. Sometimes this position is comfortable for breastfeeding and the BSN stated that the baby could potentially be at increased risk if the mother feels asleep whilst sat up as could be dropped. BSN is looking for some research related to this. Positioning and attachment is observed and staff would stay in the room to assess the feed for as long as required. They may not be there for all the feed. New/updated local safer sleep guidance attached.

Application form

- see also Hull Hospitals safer sleep guidance - attached
Teenager died as a result of meningococcal sepsis and it is deemed likely that her death would have been avoided if she had received the MenACWY vaccine before leaving for University but there was insufficient stock prior to her leaving, once she was identified as being in the cohort of patients to receive it.

'Matters of concern' in this report – i) confusion around who is responsible for keeping records to ensure those who are not vaccinated at school receive it before university, ii) unclear if GPs have a responsibility to capture unvaccinated children, iii) no form of audit to ensure GPs identify those children who are not captured in the school vaccination programme and put in place measures to protect children, particularly before attending university.

Health visitors and other professionals should do more to deliver safe sleep messages to high-risk families to reduce sudden unexpected deaths in infancy (SUDI).

Researchers have recommended that children's professionals help parents who use drugs and alcohol to develop safe sleep practices. A University of Warwick study of 27 serious case reviews involving SUDI found that if parents followed UK safe sleep guidance many of those infant deaths could have been avoided.

- In 19 of the 27 cases, parental drug or alcohol use was directly involved in the lead up to the infant's death. In 12 of the 16 cases where parents were sleeping with their infants at the time of death, substance use was a factor.

"Health visitors and midwives should be encouraged to ask both parents about their use of alcohol and other substances, and help them develop safe sleep practices, including the avoidance of co-sleeping, which can then be used when parents are affected by substances," the review concluded.

- In three of the cases involving intoxicated parents, the mothers said they ignored the safe sleep advice they had been given because they thought "it couldn't happen to me".

- Long-standing neglect was another key feature in 15 of the cases examined. This finding echoes international research that suggests SUDI now predominately occurs among deprived families.

Dr Joanna Garstang, who led the review, said: "Eleven families' siblings were reported as dirty, hungry, inadequately dressed or had severe dental caries, and seven families lived in homes described as squalid.

- "Four mothers lacked basic parenting skills, and one father was convicted for child neglect after leaving his young children home alone."

- Other risk factors identified by the review included parents' unwillingness to engage with services, which occurred in 18 of the 27 serious case reviews.
“If parents are enabled to develop and understand safe sleep practices, they may be able to keep to these if there are unforeseen circumstances,” said the review paper.

“Some families, however, are not willing to engage with services; and if there are concerns about parenting this has to be considered and managed as a safeguarding issue to ensure that vulnerable infants are protected.”

The researchers recommended that additional research into how best to deliver safe sleep messages to high-risk families is needed.....

RCM position statement supports the universal provision of baby boxes in the UK. The RCM believes that providing baby boxes where the baby has their own sleep space is likely to reduce the risks associated with unsafe co-sleeping. The position statement does stress that baby boxes must be safe, of high quality and the box and mattress should meet at least the minimum UK safety standards.

Public Health England (PHE) is undertaking a range of work with the profession to maximise midwives’ roles in prevention, safety and wellbeing in pregnancy and beyond.

A new online training module to help midwifery teams deliver very brief advice for smoking in pregnancy.

PHE has also launched a new smoking in pregnancy information pack that is exclusively for use by midwifery teams with pregnant smokers. This pack gives pregnant women new information about the harms caused by smoking to their baby. It visualises and communicates the unseen harm that happens with every cigarette. The pack also includes a myth buster, advice on the support available from local stop smoking services and tips on dealing with cravings and stress.

This edition of Health Matters focuses on the range of smoking quitting routes that are available and the evidence for their effectiveness. Find out more on the roles that different teams can play in supporting smokers to quit and helping to achieve the ambition of making England a smokefree nation by 2030. It includes calls to action for: pharmacy teams; primary care; secondary care; mental health services; maternity services; local authorities; clinical commissioning groups; local stop smoking service.

A PJGP editorial addresses the need for GPs to be vigilant in spotting measles symptoms. Despite progress in vaccine coverage in recent years the condition remains a threat to the UK population, largely because of immunity gaps in older cohorts.
Public Health England (PHE) has published the latest annual report of the UK National Screening Committee’s recommendations on whether to screen for conditions based on reviews of the best quality evidence.

The report summarises the recommendations made on 16 conditions between 1 April 2017 and 31 March 2018. These include the recommendation that screening for severe combined immunodeficiency (SCID) as part of the newborn blood spot programme should be evaluated in the NHS because evidence shows it is likely to increase the number of affected babies who would survive before and after a bone marrow transplant.

The Screening tests for you and your baby: easy guides have been well received by health professionals and the public, an evaluation project has found. This blog from Public Health England explains more.

The Government published its response to LeDeR’s second annual report on September 12.

It accepted all of the report’s nine recommendations and made a commitment to consult on mandatory learning disability training. The Department of Health and Social Care (DHSC) is now seeking the views of numerous stakeholders.

Substances taken by young people

The Guardian reports that research carried out by the University of Nottingham medical school looking at patterns and trends among 10–24-year-olds across England who overdose on painkillers and antidepressants. Findings from a study of 1,736,527 young peoples’ GP and hospital records from 1998 to 2014 include: 40,333 poisoning episodes were identified, of which 66.5% were recorded as intentional; and there were increases in poisoning incidence rates of between three- and fivefold for opioids, antidepressants, aspirin and paracetamol over the study period.

Yorkshire and Humber Children’s Palliative Care Network is working together for children and young people with life limiting and life threatening conditions across Yorkshire and Humber…..for families and professionals

The Network links together the four children’s hospices, 14 District General Hospitals, 2 tertiary centres (Leeds and Sheffield), community nursing teams, bereavement support services, local authority disability services and local special schools across our region all working together to support children and young people with life limiting and life threatening conditions.
The four children’s hospices in the region are Bluebell Wood Hospice located in Sheffield South Yorkshire, Forget me Not Children’s hospice located in Huddersfield West Yorkshire, Martin House Children’s hospice located in Wetherby North Yorkshire and St Andrews or Andy’s located in Grimsby East Yorkshire.

Rise in unexplained infant deaths prompts warning over health cuts
A charity has warned that rising child poverty levels and cuts to local authority public health budgets could result in higher rates of sudden infant death.

Rates of sudden infant death syndrome have fallen in recent years due to increased awareness of safer sleeping advice.

The Lullaby Trust raised its concerns following the publication of latest official figures for unexplained infant deaths in England and Wales, which showed the first rise in the death rate for three years.

The Office for National Statistics (ONS) reported that the unexplained infant mortality rate in 2016 was 0.31 per 1,000 live births, up from 0.28 per 1,000 live births in 2015. This represents an increase from 195 unexplained deaths in 2015 to 219 deaths in 2016.

The ONS said the rise is primarily due to a 35.5 per cent rise in "unascertained" deaths among infant girls. Unascertained deaths are those with no clear evidence of sudden infant death syndrome (SIDS) and the rise could be related to changes in how coroners certify cause of death……

There were 533,253 deaths registered in England and Wales in 2017, a 1.6% increase from 2016 and the highest number registered annually since 2003.

Age-standardised mortality rates (ASMRs) decreased for both sexes in 2017; by 0.4% for males and 0.2% for females. Both the number of deaths and age-specific mortality rates for people aged 90 and over increased in 2017, by 4.4% and 2.9% respectively; most notably for females. Age-standardised mortality rates for cancers, respiratory diseases and circulatory diseases continued to decrease in 2017, whilst rates for mental and behavioural disorders and diseases of the nervous system increased by 3.6% and 7.0% respectively.

The City of Kingston upon Hull replaced Blackpool as the local authority with the highest age-standardised mortality rate in England in 2017, increasing by 7.1% from 2016.

- The infant mortality rate increased for the first time in 5 years to 4.0 deaths per 1,000 live births; the neonatal rate also increased by 3.6% compared to 2016, whilst the postneonatal rate remained the same.
• Meanwhile, the number of infant deaths decreased in 2017, but because the number of live births decreased more significantly, the infant mortality rate rose for the first time in five years. There were 679,106 live births in England and Wales in 2017, a decrease of 2.5% from 2016 and the lowest number of live births since 2006.

• The average age of mothers in 2017 increased to 30.5 years, from 30.4 years in 2016 and 26.4 years in 1975.

• In 2017, just over half of all live births were born to parents who were married or in a civil partnership (51.9%); however, 67.3% of live births born outside of marriage or civil partnership were to parents who lived together.

• The stillbirth rate decreased to 4.2 per 1,000 total births in 2017, the lowest rate on record with figures available back to 1927; in the last decade since 2007 the stillbirth rate has decreased by 19.2%.

In 2017 there were 5,821 suicides (aged 10 years and over) registered in the UK, an age-standardised rate of 10.1 deaths per 100,000 population.

• The UK male suicide rate of 15.5 deaths per 100,000 was the lowest since our time-series began in 1981; for females, the UK rate was 4.9 deaths per 100,000, this remains consistent with the rates seen in the last 10 years.

• Males accounted for three-quarters of suicides registered in 2017 (4,382 deaths), which has been the case since the mid-1990s.

• The highest age-specific suicide rate was 24.8 deaths per 100,000 among males aged 45 to 49 years; for females, the age group with the highest rate was 50 to 54 years, at 6.8 deaths per 100,000.

• Scotland had the highest suicide rate in Great Britain with 13.9 deaths per 100,000 persons, and England the lowest with 9.2 deaths per 100,000.

*Deaths from an event of undetermined intent in 10- to 14-year-olds are not included. Although for older teenagers and adults we assume that in these deaths the harm was self-inflicted, for younger children it is not clear whether this assumption is appropriate.