Date: February 2023

7 Minute Briefing:
Impact of learning from Child Death Review Partnership

Surrey Child Death Review Partnership

1. Introduction

In accordance with the statutory guidance Working Together to Safeguard Children (2018), Child Death Review partners must make arrangements for the analysis of information from all deaths reviewed. The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they must inform them.

2. Thematic Reviews

A number of thematic reviews have been published and the action plans from these have been incorporated across the system, **ensuring they link to the Surrey Safeguarding Children's Partnership priorities of Early Help, Child and Adolescent Resilience, plus Support and Neglect.**

1. *Suicide thematic review plus 18-month update*

This work has now been incorporated into the work of the Suicide Strategy Group and actions are monitored by this group.

2. *Neurodisability*

It is envisaged that the recommendations will sit within the wider SEND workstreams.

3. *Neonatal deaths*

It is envisaged that the recommendations will sit within the wider first 1000 days and maternity workstreams.

4. *SUDI (Sudden Unexpected Death in Infancy)*

This work has been incorporated into the first 1000 days and maternity workstreams.

5. *Cancer*

This work has been presented and will be used as a baseline for future research.

6. *Cardiac Deaths*

This work has been presented, will form a lunch and learn session and provide the baseline for future research.

3. Reporting

In conjunction with our Thematic Reviews, several reports are shared across the systems at executive level for both the Surrey Safeguarding Children Partnership and Integrated Care Board.

- Annual Report
- 6 Month Update
- Annual audit of Joint Agency Report
- Safe Sleep Audit
- 4 Year Report

4. Feedback on impact of learning events on service delivery from professionals:

"Greater support for children & teachers in my school in this area of SMSC. Whole school focus and greater integration in the area of wellbeing, resilience, and other health related behaviour throughout the whole school"

"Families receive better support as a result of their loss. No important information relating to families who have experienced loss will be missed."

"To ensure that key staff and SLT are prepared for an unexpected death of a students and be aware of the support that is available for students and staff."

5. Sharing of Learning:

- 20 online lunch and learn sessions have been run since 2020 and over 900 participants have attended. Topics have included suicide, SUDI, trauma informed practice, neonatal deaths, neurodisability & supporting staff.
- 5 annual conferences have been run on child deaths, suicide, SUDI, neonatal deaths and asthma and were attended by over 700 professionals in total. As a result of the asthma conference and the work that was initiated there, Surrey Heartlands ICB received funding to be the regional pilot site for the implementation of the National Bundle of care for children and young people with asthma.
- A whole day 'Sudden unexpected death in your school' learning event was held in May 2022 and 63 Surrey schools were represented.
- 36 training sessions to frontline police, health, children's services and coronial teams to ensure they are kept up to date with the latest statutory requirements and local learning. Our team have delivered sessions at 3 Local, 2 Regional and 3 National Conferences.
- Wellbeing for Education Recovery funded training was developed locally on 'Developing a thriving school culture.' Following the evaluation, this training now has funding from Surrey County Council to continue into 2023.

6. Sharing online:

Bulletin

Learning has been shared since 2019 and all copies of the bulletin can be found at our online NHS Futures page below.

NHS Futures

Surrey Child Death Review Team - FutureNHS Collaboration Platform

Safer sleep re-audit

Safer Sleep Re-audit (surreyscp.org.uk)

7. Further Reading

Child Deaths - Surrey Safeguarding Children Partnership (surreyscp.org.uk)

PSHE Essentials wider wellbeing free training opportunities 2022 - 2023 - Healthy Surrey

Asthma Toolkit | Healthy Surrey

NHS England » National bundle of care for children and young people with asthma

SSCP-Safer-Sleep-7-Minute-Briefing-Dec-2022-1.pdf (surreyscp.org.uk)