Learning from child death reviews – dissemination to Schools in Coventry, Solihull and Warwickshire

The following is learning identified from the reviews of children and young persons of school age from across Coventry, Solihull and Warwickshire Child Death Overview Panels. Please share what you feel is appropriate. If you require any further information please let me know.

Deaths from road traffic collisions – promoting road safety:

1. 7 year old attempted to cross a road with Mother in front of a skip lorry stationary at traffic lights. Lorry started to move unaware that the child was in front of the lorry and child died from head injuries as a result of the collision. There was a pelican crossing a short distance away which Mother decided not to use.

Action:

Although Mother accepted responsibility for her actions, CDOP concluded that schools should be reminded to give regular updates on road safety to pupils, to include the use of pelican and zebra crossings. To be done via the school newsletter or via the DSL network.

2. 15 year old pedestrian stopped to cross a busy road by a pelican crossing. The pelican crossing was pressed but the young person decided to cross the road before it was safe to do so and walked into the path of an oncoming vehicle.

Action:

CDOP concluded that schools should be reminded to give regular updates on road safety to pupils, to include the safe use of pelican and zebra crossings. To be done via the school newsletter or via the DSL network.

3. 11 year old walked into the path of an oncoming vehicle on their way to school. They were wearing dark clothing on a dark winter morning and distracted by listening to music on their mobile phone.

Action:

Panel wished to ensure that road safety messages given to pupils included the dangers of being distracted by using i-pods /mobile phones etc when crossing roads and to wear high visibility clothing on dark mornings and evenings.

4. 12 year old riding on a rural road, veered onto the wrong side of the road into the path of an oncoming vehicle. The child was not wearing a helmet and was vulnerable due to having learning disabilities and problems with co-ordination.

Action:

To ascertain what advice is given by schools to raise awareness of rider safety with school age children. Also to encourage schools to sign up to cycle training for pupils such as 'BikeRight!' and ' Bikeability' which is free to schools

Other sudden and unexpected deaths:

1. 16 year old, celebrating their GCSE results, died after falling down some stairs at a friend's house whilst intoxicated through alcohol consumption.

Action:

CDOP concluded that parents and schools need to be made aware of under- age alcohol consumption at the time of exam results and to give preventative advice at these times. Public Health to also discuss with the commissioner for the School Health and Wellbeing Programme in relation to further opportunities for raising the issue of alcohol and exam result time

2. 12 year old collapsed in a friend's bedroom after sniffing fumes from an aerosol deodorant and died from oxygen deprivation to the brain.

Action:

To utilise the school newsletter to reinforce to staff the dangers of solvent abuse to pupils and for staff to look out for signs and symptoms of solvent abuse amongst its pupils.

3. A young person with a known nut allergy collapsed and died whilst out shopping after eating confectionary containing nuts. CDOP was informed that a sibling was not coping very well and was in need of professional support. The CDOP Chair informed that Solihull commission 'SOLAR', an emotional wellbeing and mental health service for those aged 0-19 years and asked that details of 'SOLAR' be shared with the Solihull Schools Strategic Accountability Board. Further to this, arrangements were made for a psychologist from the SOLAR team to come and talk at a Head Teacher's Breakfast Meeting in September 2017.

To highlight other lifestyle choices to ensure a healthier future:

The below data relates to deaths over a 9 year period from April 2008 to March 2017

In the vast majority of babies that died from extreme prematurity, maternal smoking in pregnancy was found to be the most single contributory factor, followed by a high maternal BMI, substance or alcohol misuse during pregnancy.

In the case of infants who have died from Sudden Infant Death Syndrome (also known as cot death) smoking by the mother, father, or both, was found to be a contributory factor in 76% of deaths. The consumption of alcohol or substance misuse was a contributory factor in 44% of deaths (so a combination of both smoking and alcohol/substance misuse by either parent was a factor).

32 children/young persons aged between 5-17 years died as a result of being involved in a traffic collision, with 16 (50%) being in the 15-17 age group. Of the 16, 6 were passengers, 6 were drivers/riders and 4 were pedestrians. In relation to the 6 drivers/riders**,** 5 were inexperienced drivers who had recently passed their driving test and sadly lost their lives through driver error. All 6 passengers died as a result of driver error. In relation to the pedestrians in this age group, all 4 had placed themselves in danger by walking out in front of traffic and/or wearing dark clothing on an unlit road. Consumption of alcohol and cannabis featured in 3 of the deaths in this age group in both drivers and pedestrians.

Other

1. In the review of a baby, CDOP ascertained that a 9 year old sibling was being home schooled, however no record could be found within the local authority. It was ascertained that the family had moved from another local authority area and that there was no obligation for a new LA to be notified of the home schooling arrangement if the child comes to live in their area. CDOP was concerned as this meant that a child could be living in a local authority with no agencies being aware and the safeguarding implications associated with this. This was highlighted to the Head of Service for Education and Learning.

Processes:

1. Following a road traffic collision where two 16 year old pupils and a staff member travelling in the same vehicle died, a review was conducted on the sub-regional emergency plan for Coventry, Solihull and Warwickshire which deals with emergency planning for schools to ensure they were

appropriate. The Educations Safeguarding Manager to be made aware of any changes/developments so that he can support schools if an emergency relates to a safeguarding children issue. The school was also contacted to ascertain if they were in possession of the Critical Incident Pack and the Local Authority Emergency Pack.

2. The Child Death Overview Panel Manager will routinely write to schools attended by the deceased child/young person and/or the school attended by sibling(s) to request information on the deceased child and how siblings and families are coping.

3. The Educations Safeguarding Manager wrote to all school in Warwickshire to raise the awareness of the child death review process and the importance of providing school information in relation to the deceased child and any siblings.

Good Practice:

1. To check with schools on the welfare of bereaved sibling(s) where concerns regarding their well-being have been highlighted by the school (Warwickshire).

2. In the deaths of older children, School Nurses have made themselves available in schools for students or members of staff to talk to. This had a positive effect and was particularly valuable in that it gave students who were struggling with their feelings space while school continued to function.

3. CDOP acknowledges excellent support provided by schools to the family and to the school community as a whole and feeds this back to the school concerned.

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