Trauma: Questions from our stakeholder briefing

1. **Are there any direct mention of the effects of austerity cuts to swimming lessons? (drowning related)**
   No, there wasn't, but that's because our report covered a three-year period and some of the effects of austerity might only have been shown in the later deaths that occurred during that period. That doesn't mean that it's not there though, just that we haven't been able to show it with the data we have.

   Sport England's Active Lives Survey Data does present data which shows the differences between statutory swimming attainment in children who are white and from higher affluence areas vs children from lower affluence areas and ethnically diverse children. This data is discussed in more detail in the Royal Life Saving Society UKs National Drowning Report.

2. **Do we know what type of drownings are driving the trend upwards? Is it the young people drowning in inland waterways, or is it the preschool bath drownings? How was swimming ability classified? How robustly was this measure?**
   In the appendices, we've split the drowning trends by age and clearly the mechanism of drowning is very age specific. There's not a lot of evidence that the trend is different by ages and they're all going up. The drownings are increasing in all age groups.

3. **Were there deaths of children and young people, who had a learning disability and/or autism across all categories or focused in one or two of the categories of death?**
   Within the category of trauma deaths, there were deaths of children and young people with learning disabilities in each sub-group e.g. road traffic collisions, drownings etc. However, most were in the sub-group related to violence and maltreatment. We will be doing more work in the future looking at deaths of children and young people to help place this in context.

4. **Would there be any value in repeating road safety education in secondary schools? In addition to primary school provision of road safety information.**
   Yes, there would. We should support road safety education across the board. There are resources available from the Department for Transport 'Think Campaign', which can be used in schools, which are available for all age groups from reception up to older teenagers.

5. **What contacts have you got with government agencies to ensure that the wide range of recommendations are implemented? Have NCMD made representations to the Department of Levelling Up, Housing and Communities about inclusion of window restrictors and blind cord cleats in the decent home standards?**
   NCMD is commissioned by NHS England through the Healthcare Quality Improvement Partnership. We work with colleagues in NHS England to get those government departments sighted on these recommendations, and they would have all been sighted in advance of the publication of this report. In relation to the specific question about the Department of Levelling up, yes, we have contacted Department for Levelling up to ask them to consider

window restrictors being added into the Decent Home Standards review. That was a separate communication that was sent.

6. **Did we know what breeds of dogs caused the deaths?**
   Information on the breed of dog is not collected in the data set. From the work done by Dogs Trust and RSPCA around dog safety, we know there is no one breed of dog that is more likely to be involved in an attack. The Child Accident Prevention Trust recommends looking at the resources available, familiarising yourself with the triggers that can cause dogs to bite and learning some practical steps that can be taken to keep children safe.

7. **The likelihood of these events happening away from home and a question about whether it's because the circumstances are unusual?**
   When it comes to deaths abroad/on holiday, the most common category of traumatic death was vehicle collisions, followed by drownings. What we saw with the drownings data, was that families on holiday were often excited and more relaxed and that these incidents often occurred when the family had just arrived at their destination. It was also noted that sometimes everyone thinks someone else is keeping an eye on young children.

8. **In the road collision category, was any significance made regarding the deaths increasing per year during the time of COVID lockdowns and the reduced movement in the community?**
   You actually need quite a massive increase to have a statistically significant increase in anything. Therefore, we are watching numbers carefully, but we didn't see any major trends in the pandemic at all apart from reductions of child mortality due to infection. Overall, in the lockdowns, we actually saw reductions in mortality not increases.

9. **Is there any evidence that where there are helicopters or quick response HEMS Services, this has saved lives in children? And if so, should there be more of these services throughout the country?**
   That's not something we've looked at in this report. We don't collect specific data on HEMS so we can't answer that, unfortunately.

10. **As part of the research, do you ever interview young people for example, from a youth council about their views and how to make messaging for young people more effective?**
    We have our patient and public involvement strand of work in NCMD, but it would be fair to say that engaging with young people directly is an area that we want to develop further. Currently, we rely on our charity partners to help with this. It's really important listening to young people and making sure that the language and imagery used is relevant, that it resonates and empowers them. We need to take into account the peer pressure to which young people are subject.

Unanswered Questions:

11. **In your data about learning disabilities and ASD/ADHD. Is this additive. i.e. 8% + 22%?**
    It is not necessarily additive as a child could be included within both categories if they had a learning disability and a neurodevelopmental condition.

12. **As a service that works across different areas, and seeing how JARs and CDOP panels are held, do you think there needs to be a standardised process?**
    The multi-agency guidelines for care and investigation of sudden unexpected deaths in infancy and childhood (2016), also known as the "Kennedy Guidelines", set out the processes to be followed for Joint Agency Response (JAR). However, we know these are implemented differently in different areas and one of the recommendations in this report is for these guidelines to be reviewed and updated. In terms of the child death review process itself, the Child Death Review Statutory and Operational Guidance sets out the processes to be followed when a child dies and following the publication of this document in 2018 we have seen some reduction in the variability of practice between Child Death Overview Panels (CDOPs).

13. **As there appears to be over representation in this report of children who had some form of neurodiversity/learning need - which appear to be a cohort of children who are overrepresented in other areas of concern such as exploitation. There also appears to be an overlap with neglect/complex home conditions - has there been any consideration in terms of diagnosis of these additional needs and how attachment issues can manifest through behaviour?**
    This is not an area that has been looked at by NCMD yet, however we are looking to do a thematic report on children with learning disabilities and autism in the future, in conjunction with the Learning Disability and Autism Programme which could help identify and challenges in diagnosis and assessment of these needs.

14. **Regarding the knife crime has the work that has been done in Scotland (? Glasgow) to reduce knife crime been shown to make a difference? i.e. have deaths reduced in Scotland?**
    NCMD is commissioned to collect and analyse data from children who die in England only so we do not know if knife crime deaths have reduced in Scotland as a consequence of the work that has been done there.

15. **Are there any flyers/posters around bath drowning/blind cords that can be sent out to HVs/GP surgeries/clinics? I'm so sad to see the drowning numbers showing what we have felt on the ground for over a year. The report is so valuable to raise these issues. I have been raising concerns for a recognised trend in the clinical environment for over a year along with other colleagues, but I am saddened that we are not able to be more responsive to what we see and feel is happening rather than waiting for numbers. Is there a way forward for us to work with NCMD to pick these things up sooner?**
    Royal Life Saving Society has this helpful factsheet about how to enjoy water safely at home and the Child Accident Prevention Trust's free Watch Out In Water factsheet covers bath drowning. There are also a range of free resources on blind cord safety available to download from the Child Accident Prevention Trust's blind cord safety hub.

    In terms of acting quickly, anyone can send an alert to NCMD if they have a concern about a possible emerging theme or issue. Normally this is done by CDOPs through the data collection system, however it is possible to email us and ask us to look into any issue of concern. We can then have a look at what the data shows and decide whether and how to escalate it for more urgent action.

16. **We have experienced the drowning of a child with learning difficulties, who was unable to swim. Swimming tuition for children with learning difficulties appears to be poorly covered in general swimming tuition provided through schools. Are there any recommendations being looked at for this?**
    Swim England, The Swimming Teachers Association and Level Water are three organisations that are looking at enhanced provision and support for teachers.

17. **The RoSPA Safe at Home scheme 2009-2011 supported vulnerable households with education around reducing and minimising risks in the home and also supplied and fitted a range of child safety equipment including blind cord shorteners, window restrictors, safety gates etc. The independent survey was very positive with injuries and deaths falling. Would it be beneficial to relaunch this scheme especially as we are seeing lower income families struggling to keep their children safe?**

    The National home Safety Equipment Scheme was funded between 2009-11 to provide safety equipment to targeted homes across England. It was modelled on a variety of local schemes and delivered and fitted safety equipment to around 67,000 families in the areas with the highest number of hospital admissions to under-fives for accidental injury and the families most in need. It has been evaluated as cost effective and as contributing to a reduction to hospital admissions in the target areas. Unfortunately although there is good evidence of the effectiveness of these schemes, because of the investment required there is seldom consistent investment into sustaining these programmes at local or national level. Further information can be found at Safe at home - RoSPA

    Impact of the national home safety equipment scheme 'Safe At Home' on hospital admissions for unintentional injury in children under 5: a controlled interrupted time series analysis - PubMed (nih.gov)

    Cost-effectiveness of England's national 'Safe At Home' scheme for reducing hospital admissions for unintentional injury in children aged under 5 | Injury Prevention (bmj.com)

18. **Please can you mention more about the card an individual may be given if they witness a traumatic incident. Is this meant for professionals or the general public.? My husband witnessed a child death a number of years ago and struggled with that.**
    There is a photograph of the card in the report itself (on page 19) although it is a bit difficult to see all the text. It is a pocket-sized card that opens out and describes what may happen following a traumatic event. It describes the emotional, physical and mental reactions a person may experience. It also suggests some strategies for what you can do to make things easier to bear after the incident and finally it signposts to support services including suggesting visiting your GP. This particular card is given out by the Hampshire and Isle of Wight Fire and Rescue Service to anyone who witnesses a traumatic event such as a vehicle collision.

19. **If further work is being explored on drowning data, can the survivors be included? as you may pick up more hot tub, large paddling pool numbers. Some of which will have life changing injuries.**

NCMD does not collect data on “near miss” events or those who survive a drowning experience. This is because our data is collected from Child Death Overview Panels whose exclusive remit is the review of deaths. However, the National Water Safety Forum’s Water Incident Database (WAID) is currently being enhanced to include near-miss data and once available will be a useful tool to understand the impact on survivors in more detail.

20. **Have you tracked the number of home safety injuries (eg drowning in the bath) with the decrease in the number of the health visitors?**
    No, we do not know if there is any correlation between the number of home safety injuries and the decrease in health visitors.

21. **In relation to the increase in drownings has there been a correlation with weather trends?**
    We are not able to answer this question yet as we do not have access to weather data which would help to explore this further. In the report we mention that we suspect that there might be a link between the warming climate and the number of people drowning but we cannot be sure of this, and further work is needed to establish if this is the case. However, the Royal Life Saving Society UKs National Drowning Report defines a number of measures that shows the correlation between weather events and the number of fatal incidents.

22. **I work in a rural county, and we have seen recently two deaths of young children in farm environments. They lived on the respective farms. The cause of death for both children were very different. I just wondered if there was any information around locations of deaths that is gathered that could identify any trends regarding farms or other environments?**
    The NCMD dataset includes a field that collects place of death for every child that dies and this data is published in our annual CDR data release which comes out in November each year. What is published encompasses all public places in one group and all children who died at home in another group, but it does not go down to the level of detail where it says how many deaths occurred specifically on a farm. This is because child deaths on farms are an exceptionally rare event and we do not publish numbers in order to protect the identity of individuals involved in these incidents.