Compared to the non-track process, the ASD track achieved 1) reduced default rates of 17.7%, 2) 45% reduction in psychological assessment duration, 3) 64.4% reduction in wait time for psychological assessment, 4) 63.3% reduction in ASD psychological assessment cycle time, 5) 32.8% reduction in ASD diagnostic process cycle time, 6) 28.1% reduction in clinic time usage, 7) enhanced case management and delivery of interim intervention services in family-centred manner.

Illustration – Improvements of ASD Track from Old Process

Conclusions The ASD track improved the diagnostic process and delivery of interim intervention service for Autism Spectrum Disorder in our department.

Of the patients attending a consultant/SpR clinic...

Abstract G457(P) Figure 2. This graph shows the suggested management plan for the patients analysed as a percentage of audited attendees to a Consultant/SpR led A&E follow up clinic during the period 1st June to 30th June 2014 and advising patients, performing investigations, changing dressings and relaying test results.

This audit identified an unmet need and showed that the introduction of a CCN service could reduce the number of acute hospital admissions as well as decrease the number of children returning to an A&E review clinic.

Introducing Unintentional childhood injury is a major public health problem associated with significant mortality. In Gloucestershire there have been several fatal accidents among children related to heavy furniture, blind cords and nappy bags as well as potentially harmful practices such as co-sleeping. In recent years, UK injury prevention programmes have halved the number of childhood accidental deaths. There is evidence that community-based campaigns encourage positive behavioural change and can potentially reduce the number of injuries requiring medical attention. Our aim was to explore carer awareness of four specific hazards (nappy sacks, cord blinds, co-sleeping and heavy furniture) linked to paediatric deaths within the region through the use of questionnaires and a standardised educational poster display.

Materials and methods A standardised safety awareness poster board was designed using approved charity leaflets. Six-hundred poster packs were distributed to public centres in Gloucestershire. Additionally, a questionnaire was offered to carers of children attending the Children’s centre of Gloucestershire Royal Hospital during Child Safety Week. It explored their current safety practices as well as thoughts on the usefulness and impact of the poster campaign.

Results We obtained 103 questionnaire responses over five days, 96% of which were from parents. Almost a quarter of respondents were unaware of accidental deaths relating to nappy sacks, although most (82%) kept sacks out of a child’s reach. Of the 57 respondents who had cord blinds at home 26% did not attach safety devices. Despite prominent national campaigns deterring co-sleeping, 42% of all respondents had co-slept with their children when aged less than one year old. Two-thirds...
Aims Since 2008, in England, all unexpected infant deaths must be investigated jointly by police, health and social services. This study aims to learn of bereaved parents’ and professionals’ experiences of this joint agency approach (JAA) as well as assess the effectiveness of the JAA in determining causes and risk factors for deaths and use this knowledge to improve professional practice.

Methods

1. A mixed methods study of JAA investigation of SUDI cases in one English region; involving case note analysis, questionnaires and in–depth interviews with bereaved parents and the relevant professionals.

2. A descriptive study of outcomes of JAA SUDI investigation using Child Death Overview Panel (CDOP) data.

Results

23/111 families were recruited giving theoretical saturation. The median time between infants’ deaths and parental study participation was 33 weeks; data collection took place between 2011–3. 25 professionals were interviewed. CDOP Form Cs were obtained for 65/70 (93%) SUDI cases dying during 2010–2.

Non–specialist police often arrived at the parents’ home along with the ambulance; increasing parental distress.

Parents felt that the JAA provided information about why their baby died but offered minimal emotional support.

The joint home visit by police and paediatrician is a key investigative process and most parents found this helpful. Final case discussions were used to discuss relevant risk factors but not to determine the cause of death; in nearly all cases the final cause of death relied on post–mortem examination alone ignoring findings of death scene examinations. Many deaths fitted the diagnostic criteria for SIDS but despite this were labelled as unascertained.

Social care were only involved in 13/23 JAA investigations, in two cases without involvement there were safeguarding concerns.

Some Coroner’s were reluctant to share post–mortem examination reports with paediatricians preventing effective JAA investigations.

Conclusion Ideally, SUDI investigations should be carried out only by specialist clinicians who do this work frequently and the JAA fully integrated with social care and Coroner’s investigations. There needs to be a clearer system for classifying unexplained SUDI. Police should reconsider their immediate response to SUDI; parents would like more follow–up and bereavement support from professionals.