



Bexley Local Safeguarding Children Board Procedure for Multi-Agency Response to the Child Death Overview Process

Part 1 – Rapid Response

This procedure should be read in conjunction with London Safeguarding Children Board Rapid Response Procedure (May 2009).

This procedure applies to all agencies and voluntary organisations who work with children and young people and their families in Bexley.

(Review date 1 year – April 2017)

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1. Introduction

- 1.1. This procedure has been agreed by Bexley Children Safeguarding Board (LSCB) and should be read in conjunction with the London Rapid Response Procedures (May 2009) produced by the London Safeguarding Children Board This is a multi agency procedure and not agency or discipline specific. Any agency may need to produce their own protocols in line with their professional responsibility.
- 1.2. The procedures are compliant with the requirements for the Child Death Reviews (CDOP) as outlined in *Working Together to Safeguard Children (DfE 2015)*.
- 1.3. As described in *Working Together*, there are two inter-related processes for reviewing child deaths. Either process can trigger a serious case review. The processes are:
 - Part 1 - A rapid response by a team of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child. This procedure enables the capturing of immediate information about unexpected child deaths. In addition it will assist the support to the bereaved family. The information on such cases will inform the LSCB Child Death Overview panel (CDOP)
 - Part 2 - An overview of all child deaths (birth up to 18th birthday, excluding babies stillborn) in the LSCB area, undertaken by a panel drawn from key organisations represented on the LSCB. And will contribute to learning about trends and patterns in child deaths to influence future prevention strategies.

2. Purpose

- 2.1 The purpose of rapid response is to ensure that the appropriate agencies are engaged and work together to:
 - responding quickly to the child's death in accordance with the locally agreed procedures;
 - making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;
 - liaising with the coroner and the pathologist;
 - undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations;
 - collecting information about the death;
 - providing support to the bereaved family, referring to specialist bereavement services where necessary and keeping them up to date with information about the child's death; and
 - gaining consent early from the family for the examination of their medical notes.

3. Definition of an unexpected death

- 3.1 An unexpected death is defined as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death.
- 3.2 The designated paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made.

4. Action by professionals when a child dies unexpectedly

- 4.1 **First on the scene**
All emergency services should follow their own protocols to ensure life is preserved, and children should be taken directly to an accident and emergency department.
- 4.2. When a child dies suddenly and unexpectedly, the consultant clinician (in a hospital setting) or the professional confirming the fact of death (if the child is not taken immediately to an Accident and Emergency Department) should inform the local designated paediatrician with responsibility for unexpected child deaths at the same time as informing the coroner and police. The police will begin an investigation into the sudden or unexpected death on behalf of the coroner. A paediatrician should initiate an immediate information sharing and planning discussion between the lead agencies (i.e. health, police and local authority children's social care) to decide what should happen next and who will do it.
The paediatrician who certifies death will be the on call paediatric consultant. It is this person's responsibility to ensure that the police single point of contact, coroner, and the CDOP single point of contact (SPOC) are informed as quickly as is possible following the death. This should be by the next working day. If a child is under 2 years the police contact is the Child Abuse Investigation Team (CAIT). If the child is over 2 years it is the Police Public Protection Team. *All contact details can be found in Appendix 1.*
- 4.3 If the child dies suddenly or unexpectedly at home or in the community, the child should normally be taken to an Accident and Emergency Department rather than a mortuary. In some cases when a child dies at home or in the community, the police may decide that it is not appropriate to immediately move the child's body, for example because forensic examinations are needed.

- 4.4 As soon as possible after arrival at a hospital, the child should be examined by a consultant paediatrician and a detailed history should be taken from the parents or carers. The purpose of obtaining this information is to understand the cause of death and identify anything suspicious about it. In all cases when a child dies in hospital, or is taken to hospital after dying, the hospital should allocate a member of staff to remain with the parents and support them through the process.
- 4.5 Where a child dies unexpectedly, all registered providers of healthcare services must notify the Care Quality Commission of the death of a service user – but NHS providers may discharge this duty by notifying the National Health Service Commissioning Board. Where a young person dies at work, the Health and Safety Executive should be informed. Youth Offending Teams’ reviews of safeguarding and public protection incidents (including the deaths of children under their supervision) should also feed into the CDOP child death processes.
- 4.6 If there is a criminal investigation, the team of professionals must consult the lead police investigator and the Crown Prosecution Service to ensure that their enquiries do not prejudice any criminal proceedings. If the child dies in custody, there will be an investigation by the Prisons and Probation Ombudsman (or by the Independent Police Complaints Commission in the case of police custody). Organisations who worked with the child will be required to cooperate with that investigation.
- 4.7 **Coroners** – local arrangements allow for the Coroner’s Officer in attendance to take an initial history and to inform the Designated person of any relevant information on the next working day. The Coroner’s Officer will, if possible, introduce the Child Death Overview Process to the family and provide any relevant leaflets. However, it is acknowledged that this is a very distressing time for families, and on occasions this may not be appropriate.
- 4.8 If a doctor is not able to issue a medical certificate of the cause of death, the lead professional or investigator must report the child’s death to the coroner in accordance with a protocol agreed with the local coronial service. The coroner must investigate violent or unnatural death, or death of no known cause, and all deaths where a person is in custody at the time of death. The coroner will then have jurisdiction over the child’s body at all times. Unless the death is natural a public inquest will be held.
- 4.9 The coroner will order a post mortem examination to be carried out as soon as possible by the most appropriate pathologist available (this may be a paediatric pathologist, forensic pathologist or both) who will perform the examination according to the guidelines and protocols laid down by the Royal College of Pathologists. The designated

paediatrician will collate and share information about the circumstances of the child's death with the pathologist in order to inform this process.

- 4.10 If the death is unnatural or the cause of death cannot be confirmed, the coroner will hold an inquest. Professionals and organisations who are involved in the child death review process must cooperate with the coroner and provide him/her with a joint report about the circumstances of the child's death. This report should include a review of all medical, local authority social care and educational records on the child. The report should be delivered to the coroner within 28 days of the death unless crucial information is not yet available.
- 4.11 Although the results of the post mortem belong to the coroner, it should be possible for the paediatrician, pathologist, and the lead police investigator to discuss the findings as soon as possible, and the coroner should be informed immediately of the initial results. If these results suggest evidence of abuse or neglect as a possible cause of death, the paediatrician should inform the police and local authority children's social care immediately. He or she should also inform the LSCB Chair so that they can consider whether the criteria are met for initiating an SCR.
- 4.12 **Designated person (SPOC)**– must be informed of all child deaths by telephone and notification form on the next working day. Hospitals should notify the designated person for the area in which the child resided, not the area in which the hospital is located. (*This form can be found in Appendix 2*) The designated person will assist in initiating the multi-agency Rapid Response process by informing and liaising with the police and the Designated Paediatrician for Unexpected Deaths. The designated person will take the lead in collating any agency information held in relation to the child or their family, as well as informing key senior service managers within the CYPS who may have contact with the family.
- 4.13 **Designated Paediatrician for Unexpected Deaths in Childhood** – this role is set down in the statutory guidance *Working Together (DfE 2015)*. Actions assigned to the designated paediatrician for child deaths can be delegated to a nominated senior healthcare professional unless specifically stated otherwise. The role involves:
- Leading the co-ordination of the multi-agency response, and information sharing throughout the rapid response process.
 - Ensuring all agencies are notified and actions are agreed.
 - To liaise where necessary with the Coroner in respect of information sharing and timing of the post mortem.
 - Co-ordinating a case discussion or meeting within 5-7 days of the death.
 - Co-ordinating a formal case discussion meeting within 8-12 weeks following the death if necessary. It is the designated paediatrician's decision as to whether this meeting will be necessary.

- Ensuring that a full and accurate report is provided to the LSCB CDOP using the information gathering and evaluation toolkit provided by the DfE.
- The Designated Paediatrician, following consultation with the lead clinician, is responsible for making the decision about whether a death is 'unexpected'. An interim decision may be made by the nominated healthcare professional when the designated paediatrician is unavailable (e.g. on leave), but this must be reviewed by the designated paediatrician on their return. This final decision cannot be delegated, and must be recorded with clear reference to who was involved in the discussion

5. Rapid Response Actions and Timeline

Phase 1

5.1 Usually 0-5 days – management of initial information surrounding the death of a child.

- Certifying paediatrician notifies police SPOC immediately and SPOC the next working day.
- Coroners Officer to liaise with SPOC and share any appropriate information on the next working day.
- Once the notification has been received it is the Designated Paediatrician's responsibility to decide whether it is an unexpected death, and what other information needs to be collated to inform the coroner in relation to the post mortem. At this stage a decision to hold a multi-agency meeting may be made. The rapid response template should be used for all meetings (*appendix 3*)
- A decision must be made as to whether a visit to the place where the child died should take place within 24 hours when a child dies unexpectedly in a non hospital setting. This decision should be made by the investigating police officer and Designated Paediatrician.
- This information will be used by the Paediatrician to decide if further investigations are necessary because the death is unexplained or suspicious.
- Consideration should also be given as to whether the circumstances indicate a Serious Case Review should be initiated. If this is indicated the information must be passed to the LSCB Chair for a decision.
- SPOC to undertake data checks for education and children's social care.

Phase 2

5.2 Usually 5-7 days – management of information sharing once the initial post mortem results are available.

- A case discussion between the designated paediatrician, police and pathologist should be held to consider the preliminary results of the post mortem.
- A case meeting may be held to ensure that all agencies are informed and updated and that any concerns are identified and managed. The decision to hold the meeting rests with the designated paediatrician, however, all agencies have a responsibility to ensure that any concerns they may have surrounding the death are passed to the paediatrician to inform this decision. The meeting will be facilitated by the SPOC using the rapid response template (*Appendix 3*)
- If, following the initial post mortem results, information gives rise to child protection concerns about remaining siblings and/or other children in the household a Section 47 strategy discussion will be required, in line with the London Child Protection Procedures.
- Any additional information that suggests a Serious Case Review is indicated the LSCB Chair should be informed.
- Throughout this period the needs of the family must be considered and support offered through community based services.
- The Information Gathering and Evaluation Toolkit to be updated.

Phase 3

5.3. Usually within 8-12 weeks – the management of information sharing when final post mortem report is available.

- A case discussion meeting should be convened and chaired by the designated paediatrician following the final results of the post mortem examination.
- This meeting should include those who knew the child and family and those involved in investigating the death, and the Coroners Officer.
- The purpose of the meeting is to share information to identify factors relating to the cause of death.
- Potential lessons to be learnt may be identified at this meeting and the outcome will inform the inquest if there is one. The meeting should explicitly address the possibility of abuse or neglect as contributory factors in the death. Consideration should be given to whether a Serious Case Review is indicated.
- The meeting should agree how the parents should be informed of the outcome of the meeting and how the results of the post mortem should be shared with the parents. Usual practice in Bexley is that the Coroners Officer undertakes this responsibility.
- Consideration must be given to planning the future care of the family, including bereavement support for siblings.
- A record of the meeting should be kept and forwarded to the Child Death Overview Panel and the Coroner by the SPOC and the Designated Paediatrician.

6. Care of the bereaved family

6.1. The death of a child will be a traumatic loss for a family, more so if the death was unexpected.

Bereaved family members may need help in four areas:

- Trauma
- Grieving
- Anger and self reproach
- Change

6.2. Bereaved parents should be informed of the child death overview process by a professional who has known the family previous to the death, if at all possible. The CDOP leaflet should be given to the parent usually by the coroner's officer if the child dies in hospital. (*Appendix 4*).

6.3. The family's need for bereavement support will change over a period of time and they should be made aware of who they can contact for additional support. It should be remembered that families may hold religious or cultural beliefs that may affect the grieving process and the support of their local church or community may be the most appropriate route. (*Appendix 5*)



Child Death Overview Panel Contact Details

APPENDIX 1

Dr Thomas Jacob

Consultant Paediatrician, Designated
Doctor Child Deaths

thomasiacob@nhs.net

Sarah Fisher

Police CAIT

Sarah.fisher@met.pnn.police.uk

Simon Deakin

LSCB Manager

simon.deakin@bexley.gcsx.gov.uk

Jill May

Designated Nurse Safeguarding Children/
Chair CDOP

Jill.may@nhs.net

Single Point of Contact

Jane Callagher (020 3045 4320)

BexleyCDOPadmin@bexley.gcsx.gov.uk

APPENDIX 2

CDOP Notification (Form A)

Available at: <http://www.bexleylscb.org.uk/page.php?section=policies&id=301>



Rapid Response Multi Agency Planning Meeting

A G E N D A

Purpose: To enquire into and evaluate the unexpected death of [child's name], and consider bereavement support for the family and any staff that may be affected by the death.

Introductions and apologies

Give names/agency/job title

Name of Child	DOB	DOD
Address including post code:	Contact telephone numbers:	
Parental/partner names	DOB	
Siblings names	DOB	
Any other members of the household	Any other members of the household	
Ethnicity		

Circumstance of the death to include a chronology

To include:

- a summary of what happened and when from designated paediatrician
- circumstances leading up to the death
- any observations of child/parents.
- **Confirmation whether expected or unexpected death**

Current situation relating to the death

To include:

- Police involvement – current investigations, home visits etc.
- Coroner's involvement – outcome of PM if available
- Section 47 investigation/or any need to initiate a Section 47 investigation

Historical background information

To include:

This should consider factors intrinsic to the child, parenting capacity, and factors in family/environment

- Social Services involvement – purpose/concerns/observations
- Health Visiting Services – concerns/observations
- Nursery/school – concerns/observations
- Parental information, including home circumstances, family stressors
- Factors in relation to service provision

Issues to consider

- Bereavement support for the family – who has/who will take the lead?
- Are there any actions required by the Trust's Serious Incident Protocol?
- Is a section 47 referral required (risks to other siblings)
- Serious Case review referral?
- LADO referral?
- Support for staff involved

Summary

Chair of the panel to provide a summary of the information

Recommendations/further actions

- Form B's required
- Any outstanding information needed
- Referrals
- Date to reconvene

CDOP leaflet

Available at: <http://www.bexleylscb.org.uk/page.php?section=policies&id=301>