HARROW SAFEGUARDING CHILDREN BOARD
RAPID RESPONSE PROCEDURES
Revised July 2015

1. Introduction

1.1 The vast majority of sudden child deaths are the result of natural causes and are a tragedy for any family. Every child who dies deserves to have their sudden and unexplained death fully investigated so that a cause of death can be identified.

1.2 This procedure sets a minimum standard for a rapid response service for unexpected deaths in infancy and childhood as outlined in Chapter 5 of the Government guidance *Working Together to Safeguard Children (2015)*[1].

1.3 This procedure applies when a child dies unexpectedly (excluding babies who are stillborn), or where there is a lack of clarity about whether a death of a child is unexpected.

1.4 A child is defined as any child up to the age of 18 years. All children will be subject to the Rapid Response process when their deaths are unexplained, regardless of whether they are under the care of midwives, neonatologists, or adult physicians i.e. rapid response also covers those children who are receiving predominately adult services.

1.5 It is acknowledged that each death has unique circumstances and professionals involved have their own experience and expertise, which is drawn upon in handling individual cases.

1.6 This procedure enables the capturing of immediate information about an unexpected child death while giving support to the bereaved family. This ensures that early opportunities for information gathering are not lost.

1.7 Throughout this procedure, the term “parent” is used to refer to any parent or carer, including the person with a Special Guardianship Order or Residence Order, foster parents and the local authority for those in care.

2. Responsibilities of Local Safeguarding Children Boards (LSCBs)

2.1 The Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004, specify that LSCBs are responsible for:

a) Collecting and analysing information about each death with a view to identifying-
   (i) Any case giving rise to the need for a review mentioned in regulation 5(1);
   (ii) Any matters of concern affecting the safety and welfare of children in the area of the authority;
   (iii) Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
b) Putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant person to an unexpected death.

2.2 Responsibilities in relation to Part (a) above are outlined in the HSCB's separate procedures for the Child Death Overview Panel (CDOP) -These separate responsibilities relate to all child deaths regardless of cause and the function of the CDOP sits within the remit of the HSCB.

2.3 Responsibilities in relation to Part (b) above are delivered through the HSCB's endorsement of the Rapid Response Procedures outlined in this document. The HSCB is also responsible for monitoring the effectiveness and application of these procedures. The specific tasks for individual agencies that are described within these procedures sit within the remit of their individual and collective operational responsibilities.

2.4 Rapid Response and CDOP enquiries are two separate processes, but the outcome of any Rapid Response enquiry or investigation will be reported into the CDOP process.

3. Designated Lead Professional for Rapid Response

3.1 The Designated Lead Professional for Rapid Response (henceforth referred to in this document as the Lead Professional), has responsibility for ensuring a rapid response team is formed in response to each unexpected death and that the rapid response process is carried out by the team. This role is normally held by a senior health professional.

3.2 The Lead Professional maintains senior oversight of all cases requiring a rapid response.

4. Definition of an unexpected death of a child

4.1 An unexpected death is defined (*Working Together to Safeguard Children 2015*) as a the death of a child not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.

4.1.1 Children dying at home or in a hospice or other setting who have been undergoing end of life care will not normally be considered to have died unexpectedly, and a rapid response to such deaths is rarely indicated.

4.1.2 When a child with a known life limiting and or life threatening condition dies in a manner or at a time that was not anticipated, the rapid response team should liaise closely and promptly with a member of the medical, palliative or end of life care team who knows the child and family, to jointly determine how best to respond to that child's death. Even though the child was subject to an end of life plan, rapid response actions may still be needed.

4.1.3 The Lead Professional responsible for child death 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. Although most neonatal deaths are expected, there are occasions when the Rapid Response process may need to be instigated.

5. Principles

5.1 All professionals need to strike a balance between the sensitivities of handling the bereaved parents and securing and preserving evidence which may aid them in arriving at an understanding of why a child has died.

5.2 When dealing with an unexplained child death all agencies need to follow these common principles:

- Ensuring sensitivity
- Maintaining an open mind/ balanced approach
- Maintaining an inter-agency approach
- Sharing information
- Responding appropriately to the circumstances
- Preservation of evidence

6. Rapid response remit

6.1 The service response to an unexpected child death should be safe, consistent and sensitive to those concerned, bereaved parents and siblings should receive a similar response across Harrow.

6.2 Professionals should be aware that, in certain circumstances, separate investigative processes will be taking place alongside those described in this procedure (e.g. murder investigations, SUDI processes etc.). Professionals and agencies should liaise across processes to avoid duplication.

6.3 The purpose of a rapid response service is to ensure that the appropriate agencies are engaged and work together to:

- Respond quickly to the unexpected death of a child
- Identify and safeguard any other children in the household or affected by the death
- Gather information about the child/family and those involved in their life

- Make immediate enquiries into and evaluate the circumstance of the death, in agreement with the coroner when required
- Assist in the preservation of evidence in case a criminal investigation is required
- Ensure support for the bereaved parents, siblings, family members or members of staff who may be affected by the child's death, as the death of a child will always be a traumatic loss – the more so if the death was unexpected (see www.crusebereavementcare.org.uk)
- Enquire into and constructively review how each organisation discharged their responsibilities when a child has died unexpectedly liaising with those who have ongoing responsibilities for other family members, and determine whether there are any lessons to be learned
- Cooperate appropriately post death, to maintain contact at regular intervals with family members and other professionals who have ongoing responsibilities to the family and to ensure that they are appropriately informed (unless such sharing of information would place other children at risk of harm or jeopardise police investigations)
- Consider media issues and the need to alert and liaise with the appropriate agencies
- Maintain public confidence

6.4 Rapid response begins at the point of death and ends when the final meeting has been convened and chaired by the Lead Professional for Rapid Response.

6.5 The area in which the death of a child has been declared must take initial responsibility for convening and coordinating the rapid response process, until agreement for handover can be secured with the area where the child was normally resident.

6.6 Where notified of a death abroad, the professionals responsible for child death in the local authority where the child is normally resident must consider implementing this procedure as far as is practically possible and fully record any decisions made.

7. Rapid response timeline

7.1 The Lead Professional is responsible for ensuring all actions relating to the rapid response process are completed. The rapid response timeline involves three phases:

- Immediate Response(usually 0-2 working days): the management of information sharing from the point at which the child's death becomes known to any agency, including the decision for a Home Visit to be undertaken; an assessment of who needs to be involved; and the urgency for calling the first Rapid Response Meeting
- Early Response (usually 1-5 working days): the management of information sharing at the initial Rapid Response meeting and agreed actions
- Later Response (usually 8-12 weeks): follow up Rapid Response meeting if appropriate to review the case management and discuss the final post-mortem report is available

7.2 It is important that all agencies are clear that the rapid response process is multi-dimensional, the information flow is variable, and that a number of different processes can occur at the same time e.g. child protection or criminal enquiries.

8.1 Immediate response when a child dies in the community or in hospital

8.1 Children who die unexpectedly in the community should be taken to the nearest accident and emergency department (A&E) and resuscitation should always be initiated unless clearly inappropriate. The child should **never** be taken straight to the mortuary.

8.2 The Lead Professional, police, social care and coroner must be informed as soon as possible after death has been certified. **The senior attending doctor/senior nurse will take responsibility for ensuring this happens.**

8.3 As with children who die in hospital, their parent/s should be allocated a member of hospital staff to support them, according to hospital policy.

8.4 A child should not be taken to A&E in situations where:

- The circumstances of the death require the child's body to remain at the scene for forensic examination (police will be involved in these cases and decisions will be made after consideration by the police Senior Investigating Officer); or
- The death was expected in the context of the child's life limiting condition and they were receiving palliative care; or
- The child had a do not resuscitate agreement as confirmed in the care plan[3].

In these circumstances, the professional confirming the death must inform the Coroner. The death will then be subject to local coronial guidelines.

8.5 The families of children who are not taken to hospital should receive support throughout the process from a professional whose role is to provide such support.

9. On arrival at hospital

9.1 It is important to respond quickly to the unexpected death of a child. As soon as practicable (i.e. as a response to an emergency) after arrival at a hospital, the child should be examined by the consultant paediatrician or delegated senior paediatric clinician on call. In some cases, this examination might be undertaken jointly with a consultant in emergency medicine, or for some children over 16 years of age, the consultant in emergency medicine may be more appropriate than a paediatrician.

9.2 A detailed and careful history of events leading up to and following the discovery of the child's collapse should be taken from the parents/carers. Best practice is to take a history from the parents/carers separately, although it is recognised that this may sometimes be impracticable. This recognises that

clinical consultations have greatest evidential value if it is possible to establish the pattern of consistency and inconsistency in the accounts of the carers.

9.3 Where parents do not understand or speak English well, an interpreter should be called. The interpreter should not normally be a family member. However, urgent information about the child can be sought from a family member whilst awaiting an interpreter to arrive.

9.4 It is important to document **all** that is said by the family in a precise and non-judgmental fashion. This may be crucial to the evidence required by the Coroner and/or any subsequent investigation.

9.5 Where the cause of death (or factors contributing to it) is uncertain, investigative samples and X-rays should be taken immediately on arrival prior to the death being certified.

9.6 In seeking to clarify the cause of death and the facts which contributed to it, the paediatrician should document:

- A full account of any resuscitation and any interventions or investigations carried out;
- An account by the carer, including narrative, of the events leading to the death; and
- A body chart documenting the examination findings and any post-mortem changes.

9.7 Following the pronouncement of the child's death, staff should inform the parents of the subsequent processes that will take place, including the Rapid Response process.

NB. In addition to the Rapid Response Process, the CDOP Form A should be completed by all relevant agencies within 24 hours and sent to the CDOP Co-coordinator.

10. Involvement of the Coroner

10.1 Once death has been declared the coroner assumes immediate responsibility of the child's body and no further samples for investigations may be taken without the Coroner's permission.

10.2 Permission should also be sought from the Coroner for the removal of, for example, a lock of hair, foot or hand print, or the taking of a photograph for a 'memory box' for the family.

10.3 No items (e.g. clothing) should be returned to the parents without consultation with the Coroner and Police Officer involved.

11. Rapid Response Discussion

11.1 The Lead Professional must ensure that information is shared and initiate a planning discussion between relevant agencies such as the police, health (e.g. ambulance staff, named and designated doctors/nurses, liaison health visitor, general practitioner, midwife, pathologist), Local Authority children's social care and relevant others, including the Coroner's office, in a timely manner to decide next steps. This may or may not involve a meeting.

11.2 Where an unexpected death occurs in a hospital, the plan should also address the actions required by the Trust's Serious Unexpected Incidents Protocol (SUI). Where the death occurred in a custodial setting, the plan should ensure appropriate liaison with the investigator from the Prisons and Probation Ombudsman.

11.3 For each unexpected death of a child (including those not seen in A&E) urgent contact should be made with any other agencies who know or are involved with the child (including community health, CAMHS, school or early years) to inform them of the child's death and to obtain information on the history of the child, the family and other members of the household. If a young person is under the supervision of the Youth Offending Team they should also be approached.

12. Immediate support for the family

12.1 This is a difficult time for everyone. The time spent with the family may be brief but actions will greatly influence how the family deals with the bereavement for a long time afterwards.

12.2 Remember that families are in the first stages of grief. They may be shocked, numb, withdrawn, angry or hysterical.

12.3 The family should be allocated a member of staff to remain with them and support them throughout the process. The family should normally be given the opportunity to hold and spend time with their child in a quiet designated area. The allocated member of staff should maintain a discrete presence throughout.

12.4 Before leaving the hospital, or if the child died at home, before the professionals leave the home, the parents should be given details for the Rapid Response team so they are able to liaise with one person only. Parents should be kept informed of the whereabouts of their child.

12.5 Communication with parents/family at this early stage is critical.

- The Rapid Response meetings should determine who will lead the communications with the parents/carers and liaise on their behalf for example with the Coroner's Office where required
- Communications should be clear, sensitive and honest
- Parents should be treated with compassion, respect and dignity
- Every effort should be made to conduct discussions in a private and sympathetic environment, away from interruptions

- The child should be referred to by name and s/he always handled as if s/he were still alive
- It is important to take into account religious and cultural beliefs which may impact upon procedures. In all but exceptional circumstances, i.e. when crucial forensic evidence may be lost or interfered with, this should be allowed, albeit with observation by an appropriate professional
- The family should be informed that the death will be notified to the coroner and a post-mortem will be required. They should also be informed of the involvement of the police and social care
- Verbal communication may need to be complemented with written material

13. Multi-agency involvements

13.1 The involvement of the police is a statutory requirement and does not assume suspicion.

13.2 Where the death is unexplained and there are concerns about abuse or neglect, the police will be the lead agency. It will be the responsibility of all relevant partner agencies to support the police investigation. It is therefore, vital that staff maintain accurate records of their involvement with the family so that all relevant information can be obtained effectively and in a timely manner.

13.3 The family may well be in need of support services and any other children within the family may be in need of protection. Inter-agency collaboration is therefore essential. Staff need to be aware that on occasions, the early arrest of the parent/s-carer/s may be essential in order to secure and preserve evidence as part of an investigation.

13.4 Staff should always identify and enquire about the siblings and ensure they are being cared for appropriately, taking account of possible risks to other children in the household.

14. Police investigation

14.1 The police will begin an investigation into the unexpected death of a child on behalf of the coroner. They will carry this out in accordance with relevant Association of Chief Police Officers guidelines.

14.2 The responsibility for a Metropolitan Police investigation into the death of a child depends on a variety of factors. The following is a summary of the specialist units who would take primacy of an investigation.

- The Child Abuse investigation unit (CAIT) will investigate sudden and unexpected death in infancy of children under the age of 2 within the family

- The murder of a child will be investigated by the homicide command, SC&01.

- The death of a child following a road traffic collision within Harrow Borough will be investigated by the serious collision investigation unit. This unit forms part of the Pan London Road and Transport Policing Command.

- The unexpected death of a child aged 2 or older and under 18 will be investigated by local officers.

The various investigation teams listed above can be contacted via the CID at Harrow Police Station.

15 Immediate Action: Potential visit to the place where the child died

15.1 When a child dies unexpectedly in a non-hospital setting the senior investigating police officer and Lead Professional should make a decision about whether a visit to the place where the child died should be undertaken and the timing and decision as to who undertakes the visit is clarified.

15.2 The purpose of the home visit is to gather information which may provide immediate insight into the cause of death, or which may later prove significant to the coroner or to any criminal investigation or may prompt a child protection referral. The visit can also provide support to the family as part of their bereavement process.

16. Initial Rapid Response Meeting

16.1 A case discussion should take place as soon as practicable and within one week of the child's death, in order to:

- Ensure the right support is available for the family
- Ensure all agencies are aware of their roles and responsibilities
- Review the preliminary post-mortem results (if available)
- Identify any safeguarding concerns around surviving children
- Ensure all relevant agencies are involved in the process
- Identify what further investigations or enquiries are required, agree which agency will undertake each task and agree timescales (which may not exceed those set out in this procedure). If abuse or neglect appear to be possible cause of death, LA Children's Social Care and the Police should be informed and Serious Case Review Procedures considered by Harrow Safeguarding Children Board
- Consider any media issues and have an agreed process for managing it
- To agree how and by whom the parents will be informed about the post-mortem results and the outcome of the meeting.

NB. At the very least, this meeting should include those involved in the acute management of the case; those involved in the long term care of the child and family, police, social care and if appropriate, representatives from education.

17. Involvement of the Coroner

17.1 If deemed necessary (and in almost all cases of an unexpected child death it will be), the coroner will order a post-mortem examination to be carried out as soon as possible.

17.2 Where the death may be unnatural, or the cause of death has not yet been determined, the coroner may in due course hold an inquest.

18. Review Rapid Response Meeting: Usually within 8-12 weeks

18.1 A further case discussion meeting should be convened and chaired by the Lead Professional to discuss any further results that have become available and to assess how the family are managing at this difficult time – and to ensure any actions highlighted at the initial meeting have been implemented. Again, this should involve those who knew the child and family and those involved in investigating the death – the GP, health visitors, school nurse, paediatricians, pathologist (or pathologist report), police senior investigating officers, Coroner (Coroner's office) and, where relevant, social workers.

18.2 Prior to this meeting, the Designated Paediatrician should discuss the case with the pathologist (when a post-mortem has taken place and consent obtained from the coroner) and the police senior investigating officer, where appropriate.

18.3 At all stages the process should explicitly address the possibility of abuse or neglect as causes or contributory factors in the death, and the outcomes of this should be recorded.

18.4 Where other investigations are ongoing, the meeting should conclude with a record of the current situation and decide whether a further meeting is required and when.

19. Media issues

19.1 The HSCB should have a process for managing media interest. Staff must be enabled to proceed with their functions without intrusion and the family provided with privacy.

19.2 Any information released to the media must be agreed by all relevant HSCB partner agencies via their respective Press Offices.

20. Support for Staff

20.1 Child deaths will have varying degrees of impact on staff. Agencies need to be aware that clear procedures, effective communication and leadership will provide staff with confidence and enable them to respond appropriately to families. Staff may respond to the emotions involved and agencies should have arrangements in place to manage this.

20.2 Where required, staff should be offered support through a formal debrief system and counselling via relevant welfare support provided by the place of work.

Useful Contact Numbers

References

1. Working together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children. HM Government. 2015 DCSF
2. www.resus.org.uk/pages/guide.htm
3. See also DCSF Information sheet: Deaths in Children with Life-Limiting Conditions at: http://childdeath.ocbmedia.com/public_docs/iInformation%20Sheet%20-%20Deaths%20in%20Children%20with%20Life-Limiting%20Condidtions.pdf
4. www.rcpath.org/resources/pdf/SUDI%20report%20for%20web.pdf
5. Sudden Unexpected Death in Infancy: a multi-agency protocol for care and investigation.
   The report of a working party convened by the Royal Colleges of Pathologists and the Royal College of Paediatrics and Child Health (2004). London: RCPath