Joint Guidance Between Staffordshire & Stoke on Trent Local Safeguarding Children Boards

PART 10-D

WHEN A CHILD DIES

D - Responding to Sudden and Unexpected Deaths in Childhood - (Infants and Children under 18)

Brief Process Model for Rapid Response Procedures, Including Data Collection Requirements

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Appendix 1

When a Child Dies Suddenly or Unexpectedly

1. Professionals involved (before or after death) should come together to enquire into and evaluate the child's death.

2. This process will be co-ordinated by the designated doctor for unexpected deaths in childhood (DDUD). The DDUD will supply the Police with a list of personnel responsible for DDUD duties out of hours. It the responsibility of the DDUD to ensure that cover is in place.

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Child Protection Context/Criminal Investigations

3. Processes for dealing with sudden/unexpected deaths in childhood do not supersede child protection enquiries procedures (as described in Chapter 4 of the Staffordshire SCB Inter-Agency Safeguarding Procedures and separately in the Stoke on Trent Inter-Agency Safeguarding Procedures). Where abuse or neglect is suspected in relation to the child and/or surviving siblings these procedures will apply and run concurrently with procedures for sudden and unexpected death in childhood. The police remain responsible for criminal investigations.

Serious Patient Safety Incidents

4. Where a child dies unexpectedly, all Trusts, including PCTs, should follow their locally agreed procedures for reporting and handling serious patient safety incidents.

Serious Case Reviews

5. If at any point following the death of a child it is thought that the criteria for a serious case review might apply, the Manager of the respective LSCB should be contacted.

BRIEF PROCESS - PHASE 1
USUALLY 0-5 DAYS
RAPID RESPONSE

Ambulance Crew

6. Ambulance staff will usually attempt resuscitation and will take contemporaneous notes of their involvement and observations. The child will usually be transported to the local Accident and Emergency Department.

Child who is taken to Hospital/Dies Unexpectedly in Hospital

7. A child who is confirmed dead in the community will usually be transported to A&E for further assessment. The professional confirming the death will inform the DDUD.

8. Child will be examined by the on-call consultant paediatrician.

9. A detailed history of events will be taken from the parents/carers. For SUDIs see first interview/Home Visit data check list at Part 10-G.

10. A check to the child protection register/successor database re: children subject to a child protection plan will be made.

11. Where the cause of death is uncertain, investigative samples should be taken upon arrival at the hospital and after the death is confirmed. These should be agreed in advance with the coroner. For all children up to 2 years a skeletal survey should be undertaken.

12. When the baby/child is pronounced dead, the consultant clinician involved will inform parents, explaining to them the requirement for contact to be made with the Coroner, the Police and with Children's Social Care.

13. The consultant clinician involved will contact:
    - the Coroner
    - the Police
    - the Designated Doctor for unexpected deaths in childhood (DDUD).

In All Cases where a Child has Died Unexpectedly

14. The professional confirming the death informs the DDUD immediately after the Coroner has been informed in normal working hours. Out of hours a message should be left for the DDUD.

Information Sharing/Planning - Case Discussion 1

15. The DDUD is responsible for co-ordinating the multi-agency response.

16. The DDUD or their representative informs the Coroner, the Police, the on-call paediatrician, Children's Social Care, the Health Visitor/School Nurse to initiate an immediate information sharing/planning discussion between the lead agencies - (Police, Health, Children's Social Care). This will usually occur on the telephone and may be a series of discussions.

17. As soon as is possible the DDUD will inform the Central Point of Contact (Child Death Overview Panel Co-ordinator) of the death via telephone, following up by forwarding Form A - Notification of a Child Death. They will further inform the relevant Director of Public Health.

18. Children's Social Care may, at this point, have already been contacted by A&E/The Police, dependent upon the circumstances of the case. They should make checks to the CPR/successor database recording children subject to a child protection plan for the deceased child, surviving siblings and any child living in the same household. The client information system should be checked in relation to the deceased child, survising siblings, any children living in the same household, parents, carers and other relevant adults.

19. All cases regarding unexpected death in childhood should be allocated to a Safeguarding Team within Children's Social Care, unless a caseholding social worker is in place. Depending upon the circumstances of the death, CSC involvement may be brief, making case closure after the immediate information sharing discussion appropriate. Case closure should be agreed with the DDUD and the Police.

20. The need to invoke the child protection procedures in relation to surviving siblings should be given immediate consideration by Children's Social Care.

21. If the child has died away from home, contact with other LAs should be undertaken by Children's Social Care.

22. This information sharing/planning discussion should agree what should happen next and who should do what. It should confirm the lead health/police/social care professionals to aid subsequent contacts. Urgent contact should be made with other agencies involved and this will normally be undertaken by Children's Social Care on behalf of involved agencies.

23. If a strategy meeting is required regarding surviving siblings this should occur as soon as possible and always within 72 hours. Immediate actions to protect surviving siblings may be required.

24. The Police will begin an investigation on behalf of the Coroner.

25. The senior investigating police officer/DDUD, will decide if a home visit is needed when children have died unexpectedly in a non hospital setting, who should be involved in this visit and when it will occur.

26. Such a visit should occur within 24 hours of the death and should always be considered for sudden infant deaths.

27. For most unexpected child deaths the Coroner will order a post mortem examination.

28. The DDUD will continue to collect information and share this with the pathologist and the coroner.

29. The Police Officer in Charge should ensure that a report of all known information is provided to the Coroner within 28 days.

DATA COLLECTION - CORE DATA SET FORM B - AGENCY REPORT FORM (SEE PART 10-G) During this initial stage all agencies should start to complete Form B with information they hold. The CDOP Co-ordinator will collate all Form B's upon completion of agency involvement.

BRIEF PROCESS - PHASE 2
USUALLY 5-7 DAYS

Case Discussion 2 - Following the Preliminary Results of the Post Mortem Examination Becoming Available

30. The DDUD is responsible for co-ordinating this case discussion, between the DDUD, the pathologist and senior investigating police officer. The Coroner should be informed of the initial results and Children's Social Care should be updated.

31. The discussion may be conducted via telephone. More complex cases may require the DDUD to convene a meeting of involved professionals.

32. This discussion may trigger a child protection referral for surviving siblings or referral for a potential serious case review.

DATA COLLECTION - CORE DATA SET
FORM B - AGENCY REPORT FORM (SEE PART 10-G)
FORMS B2-B11
During this second stage all agencies should continue to populate their own agency copy of Form B. The DDUD should ensure completion of any relevant supplementary Form B2-B11 specific circumstance recording forms (See Part 10-G).

FORM B COLLATION
Each agency should complete Form B (it is not expected each agency will complete all parts) and forward it to the CDOP Co-ordinator who will collate the Form B into one document in advance of the Final Case Discussion.

BRIEF PROCESS - PHASE 3
USUALLY 8-12 WEEKS

Case Discussion following the Final Results of the Post Mortem

33. This should generally be an actual meeting which the DDUD is responsible for convening. Those professionals involved with the child/family and those reviewing the death should be invited.

34. Possible attendees will include:

DDUD
GP
Health Visitor/School Nurse
Paediatrician/s
Pathologist or Pathology Report
Police Senior Investigating Officers
Coroner or Coroners Officer
Social Worker (where relevant)

35. The purpose of this meeting is to:

- share information to identify the cause of death/contributory factors
- plan future care of the family
- inform the inquest
- identify potential learning
- explicit discussion of abuse/neglect causing or contributing to the death

- agree process for sharing detailed information about the cause of death
- agree the provision of ongoing support to families, including how parents will be informed about the outcome of the meeting.

36. The results of the post mortem examination should be shared with the parents and this should be arranged by the DDUD. This sharing must be consistent with the requirements of the Coroner and Police enquiries.

DATA COLLECTION - CORE DATA SET
FORM'S B-B11 - The CDOP Co-ordinator will make a collated Form B available for this final case discussion.

DATA COLLECTION - ANALYSIS PROFORMA FORM C - (See Part 10-G)
The group of professionals called together by the DDUD for the Final Case Discussion should complete Form C - Analysis Proforma.

DATA COLLECTION - AUDIT TOOL FOR RAPID RESPONSE FORM D - (See Part 10-G)
The group of professionals called together by the DDUD for the final case discussion should complete Form D - Audit Tool for Rapid Response.

DATA COLLECTION - POST MORTEM INFORMATION FORM B11 - SUMMARY OF POST MORTEM FINDINGS
This form should be presented to/forwarded to the Final Case Discussion from the Pathologist

37. All minutes and data collection sets from this final case discussion should be forwarded to the Child Death Overview Panel Co-ordinator and the Coroner.

38. If Children's Social Care have continued as contributors to all 3 stages, the file of the deceased child should be closed at this point if ongoing support services are not required by the family. Cases of surviving siblings may need to remain open.

Appendix 1

RAPID RESPONSE FLOWCHART