Wiltshire and Swindon Rapid Response and Child Death Protocol for Unexpected Deaths

- This protocol relates to unexpected deaths of children up until the age of 18 and sets out the roles and responsibilities for those agencies who are involved with responding to unexpected deaths as part of the child death process – police, health professionals and children’s social care, across Wiltshire and Swindon and reflects roles and responsibilities set out in Working Together to Safeguard Children 2015.

- The three main hospitals who will receive children from Wiltshire and Swindon and to whom this protocol relates are Great Western Hospital, based in Swindon, The Royal United Hospital, based in Bath and Salisbury Foundation NHS Trust Hospital, based in Salisbury.

- This protocol sets out the role of the Lead Paediatricians for responding to child deaths, who are commissioned by the relevant Clinical Commissioning Group (CCG) to lead the child death process, including home visits (for the west of Wiltshire), arranging and leading the Rapid Response and Local Case Review (LCR) meetings.

The Lead Paediatrician may be referred to by different titles in the various Hospitals

  - For the Royal United Hospital it is the Consultant Community Paediatrician who will co-ordinate and lead the Rapid Response process including the rapid response meeting and Local Case Review.
  - For Salisbury NHS Foundation Trust Hospital the Consultant Paediatrician on call will provide immediate response to a child coming into the Hospital and will co-ordinate and lead the rapid response meeting(s). The Named Doctor will co-ordinate and lead the Local Case Review.
  - For the Great Western Hospital the Paediatric Consultant of the Week (COW) or Consultant Paediatrician on call will provide the immediate response to a child coming into the Hospital and will co-ordinate and lead the initial rapid response meeting(s). The Named Doctor will co-ordinate and lead the Local Case Review.

- For children from other parts of Wiltshire and those in Swindon, home visits are currently undertaken by health responders – school nurses and health visitors. Health responders should be invited to and attend the Rapid Response meetings and the hospital at the initial stage as appropriate to the service offered at Salisbury NHS Foundation Trust and Great Western Hospital (not currently 24 hours response).
What is an unexpected death?

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.

1. If a child dies suddenly and unexpectedly, the consultant paediatrician at the hospital or the professional confirming the death (if the child is not taken immediately to an Accident and Emergency Department) should inform the Lead Paediatrician for child deaths at the relevant hospital at the same time as informing the coroner and police. Each hospital (RUH, GWH and Salisbury) has different arrangements for provision of lead paediatricians who respond to child deaths as set out above. A Key Contacts sheet is available separately to support professionals in contacting other agencies when a child dies.

2. The police will be immediately notified and begin an investigation into the sudden or unexpected death on behalf of the coroner.

3. The Lead 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. (See Flow Chart).

If professionals are uncertain about whether the death is unexpected, the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made.
Flow Chart: Process for rapid response to the unexpected death of a child

Unexpected child death

- Ambulance and police immediate response
- Assess immediate risks/concerns
- Resuscitation if appropriate
- Police consider appropriate scene security
- Consider needs of siblings and other family members

- Where appropriate, child and carer(s) transferred to hospital with paediatric facilities; resuscitation continued/decision to stop
- Hospital staff notify police
- Lead police investigator attends hospital

- Responsible clinician confirms death and notifies Lead Paediatrician
- Support for carer(s) and other family members
- Initial discussion between Paediatrician and attending Police Officer
- Lead Paediatrician (where possible, jointly with attending Police Officer) takes detailed history and does examination, whilst acute team take samples and performs immediate investigations

Initial information sharing (Rapid Response) and planning meeting/discussion co-ordinated and led by Lead Paediatrician. If abuse is known or suspected this will be a Strategy Meeting arranged and led by Childrens Social Care. * there may be more than 1 meeting as appropriate to the circumstances of the case

Joint home visit by Police and Lead Paediatrician/health responder – (may occur before RR meeting as appropriate in the case)

Coroner arranges autopsy

Autopsy and ancillary investigations

Further Police investigations — Review of health and social care information. Agencies complete Form B’s and send to Child Death Office

Local Case Discussion chaired by Named Doctor/Lead Paediatrician (CDOP office provide help in arranging this meeting) – Review of the circumstances of the death – On-going family support including appropriate feedback of outcomes of Local Case Discussion

Coroner’s Inquest

Child Death Overview Panel

Hospital staff notifies:
- Coroner
- CDOP Office
- GP
- Other health organisations
- Children’s social care

Lead Paediatrician provides report for Coroner, Pathologist. And CDOP office

Preliminary and final autopsy report provided to Coroner, and with Coroner’s agreement to Lead Paediatrician

Report of Local Case Discussion provided to Coroner and CDOP office by Lead Paediatrician

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1. The joint responsibilities of the all professionals involved with the child include:

- responding quickly to the child’s death;
- following the rapid response protocol;
- 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;
- considering and providing support as appropriate 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.
- informing the CDOP office and completing a “Form A” to notify the death and a “Form B” to provide further information on the death (although a copy of the report sent to the Coroner may be used in lieu of a Form B to avoid creating additional work)

2. Immediate Action

1. If the child dies suddenly or unexpectedly at home or in the community, the child should normally be taken to an 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.

2. 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, 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.

3. If the child has died at home or in the community, the lead police investigator and Lead Paediatrician or Health Responder should decide whether there should be a visit to the place where the child died, how soon (ideally within 24 hours) and who should attend. This should almost always take place for cases of sudden infant death.
3. **Notifications - who needs to be informed when a child dies unexpectedly**

1. Hospital staff should inform the following agencies when a child dies unexpectedly, within 2-4 hours of death:
   - Police
   - Coroner
   - CDOP Office
   - GP (as soon as possible if child dies out of office hours)
   - Other health organisations
   - Children’s social care (EDS out of hours)

2. Agencies should have clear processes for notification within their own agencies; however notification must be made to the Safeguarding Children Board (via the Board Manager) and the Designated Nurse for Safeguarding by MASH/Children’s Social Care. Where there is a suicide/suspected suicide then Child & Adolescent Mental Health Services (CAMHS) should also be notified by MASH/Children’s Social Care.

3. Where a child dies unexpectedly, all registered providers of healthcare services must notify the Care Quality Commission of the death of a service user – although NHS providers may discharge this duty by notifying the National Health Service England.

4. 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 as appropriate.

5. 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.

6. 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. **Initial Information Sharing (Rapid Response) Meeting – 24-48 Hours**

1. After the home visit the senior police investigator, Lead Paediatrician, GP, health responder and local authority children’s social care representative should be involved in a rapid response meeting to share appropriate information about the child/family and plan next steps.

2. This will be called a Strategy Discussion rather than a Rapid Response meeting where abuse is known or suspected to be a factor in the death.
3. There may be emerging concerns or suspicions within a Rapid Response meeting of abuse or neglect in relation to the death. If this is the case then members need to agree that the meeting now needs to become a Strategy Discussion and therefore chaired by children's social care (and be recorded as such).

4. There may be a number of Rapid Response/Strategy Discussions/meetings depending on the nature and complexity of the death.

5. **Involvement of the Coroner and Pathologist**

1. If a doctor is not able to issue a medical certificate of the cause of death, the lead paediatrician or police investigator must report the child's death to the coroner. The coroner must investigate violent or unnatural deaths, or deaths 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.

2. The coroner will order a postmortem 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 lead paediatrician will collate and share information about the circumstances of the child's death with the pathologist in order to inform this process.

3. 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.

6. **Action after the Post Mortem**

Although the results of the postmortem belong to the coroner, it should be possible for the Lead 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 Lead Paediatrician should inform the police and relevant social care team immediately. They should also inform the relevant LSCB Chair in area that the child lived so that they can consider whether the criteria are met for initiating a Serious Case Review.

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7. **Local Case Review**

1. Shortly after the initial post mortem results become available (approximately 7 – 10 days after death), the Lead Paediatrician/Named Doctor needs to convene a local multi-agency case discussion (Local Case Review), that includes all those who knew the family and were involved in investigating the child's death (the CDOP office will help to arrange this). A further Local Case Review meeting should be arranged as soon as the final post mortem results become available (approximately 3-6 months in most cases).

2. The CDOP Office will have sent out Form B’s to be completed by those professionals who knew the child/ young person or members of their immediate family. The Form B’s must be completed in a timely fashion and returned to the Child Death Office to inform the Local Case Review.

3. The professionals attending the LCR will review and share any further available information, including any that may raise concerns about safeguarding issues. This is in order to discuss information about the cause of death or factors that may have contributed to the death and to plan future care of the family.

4. The Lead Paediatrician/Named Doctor will complete a Form C and arrange for a record of the discussion to be sent to the coroner, to inform the inquest and cause of death, and to the relevant CDOP, to inform the child death review. At the case discussion, it should be agreed how detailed information about the cause of the child's death will be shared, and by whom, with the parents, and who will offer the parents on-going support.

8. **Child Death Overview Panel (CDOP)**

Wiltshire and Swindon LSCB’s operate a joint CDOP, which is made up of members from both LA areas and different organisations.

The purpose of the CDOP is:

- reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- discussing each child’s case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
• determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
• making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
• identifying patterns or trends in local data and reporting these to the LSCB;
• where a suspicion arises that neglect or abuse may have been a factor in the child’s death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
• agreeing local procedures for responding to unexpected deaths of children; and
• cooperating with regional and national initiatives – for example, with the National Clinical Outcome Review

The CDOP:

• Meet on a quarterly basis

• Provide an annual report to both LSCB’s

• Will take forward and address service issues where identified at a local or national level
Flow Chart: Process to be followed for all child deaths

Child Dies

Any person to notify the CDOP Office, via completion of Form A, which should be sent to: St Michael's Hospital, Bristol BS2 8EL or by Telephone: 0117 342 5277 or Fax: 0117 342 5154 or Email: ubh-tr.cdop@nhs.net

Home Visit by Police and Paediatrician/Health Responder

CDOP Office to send agency report – Form B – to lead professionals and any other professional known to have been involved

Local Child Death Review meeting takes place within 6 months of death unless a post mortem is required. Form B’s to be sent to Chair of CDR meeting one week before.

All Form B’s to be returned to CDOP Office – within three months of death by secure transfer

Form C completed by Chair of CDR meeting and sent to CDOP office. CDOP office to compile anonymous case record from Forms A, B and C for presentation to CDOP panel

CDOP meeting to review each case brought before it to:
- Agree the cause of death
- Agree any modifiable factors
- Consider whether to make recommendations and to whom they should be addressed

If CDOP unable to classify the death, or adequately review it, from information available, decide whether further information could be obtained

If appropriate, case review to be rescheduled

Recommendations to be submitted to LSCB and any other relevant body

LSCB to make arrangements to ensure actions are taken as appropriate

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