
# Multi Agency Policy for Child Deaths in Jersey

June 2014

# Rapid response service for unexpected child deaths

## Introduction

The following document seeks to set out processes to be followed when a child dies unexpectedly in Jersey.

Our 'Safeguarding Partnership Board' is not a Statutory body and these procedures are not legally enforceable. However they are based on best practice guidance from England and provide a framework for the above and should be read in conjunction with Chapter of 5 of Working Together to Safeguard Children 2013.

## 1. Definition of an unexpected death of a child

1.1 An unexpected death is defined as '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'.

1.2 The on call paediatrician or equivalent, 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.

1.3 A child is defined as 'any person under the age of 18 years'.

## 2. Rapid response remit

2.1 The services response to an unexpected child death should be safe, consistent and sensitive to those concerned, bereaved parents and siblings should receive a similar response.

2.2 Professionals should be aware that, in certain circumstances, separate investigative processes may 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.

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

- Ensure support for the bereaved family members, as the death of a child will always be a traumatic loss - the more so if the death was unexpected;
- Identify and safeguard any other children in the household or affected by the death;
- Respond quickly to the unexpected death of a child;
- Make immediate enquiries into and evaluate the reasons for and circumstances of the death, in agreement with the Deputy Viscount (as Coroner);
- Enquire into and constructively challenge how each organisation discharged their responsibilities when a child has died unexpectedly (liaising with those who

have ongoing responsibilities for other family members), and whether there are any lessons to be learnt;

- Co-operate appropriately post death, maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities to the family, 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;
- Provide bereavement support as needed, for any other children, family members or members of staff who may be affected by the child's death.

2.4 Rapid response begins at the point of death and ends when the final meeting has been convened and chaired by the on call paediatrician or equivalent. Any records of the meeting (meeting notes) should be forwarded to the chair of the SBP at the time of the review.

2.5 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.

## 3. Rapid response timeline

3.0 The Designated paediatrician or equivalent is responsible for ensuring all actions relating to the rapid response process are completed. The rapid response timeline involves three phases:

- **Phase one (usually 0-5 days)**: the management of information sharing from the point at which the child's death becomes known to any agency until the initial results of the post-mortem have been completed;
- **Phase two (usually 5-7 days)**: the management of information sharing once the initial post mortem results are available; and
- **Phase three (usually 8-12 weeks)**: the management of information sharing through the case discussion meeting when the final post-mortem report is available.

3.1 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.

### Phase I: usually 0 - 5 days

### Immediate response

3.4 Children who die unexpectedly in the community should be taken to an accident and emergency department (A&E)

rather than a mortuary, and resuscitation should always be initiated unless clearly inappropriate.

3.5 As with children who die in hospital, their parent/s should be allocated a member of hospital staff to support them throughout the process.

3.6 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) and liaison with the Deputy Viscount; or
- The death was expected in the context of the child's life limiting condition and they were receiving palliative care.

3.7 Where a child is not taken immediately to A&E, the professional confirming the death should inform the Deputy Viscount, and the on call paediatrician at the earliest opportunity. This death will be subject to local procedure if the doctor is unable to issue a Medical Certificate of the Cause of Death.

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

**On arrival at hospital**

3.9 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. 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.

3.10 Where the causes of death or factors contributing to it are uncertain, investigative samples should be taken immediately on arrival and after the death is confirmed and with the authorisation of the Deputy Viscount. Consideration should always be given to undertaking a full skeletal survey and may include a CT/MRI scan prior to autopsy.

3.11 In seeking to clarify the cause of death and the factors 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.

3.12 When the child is pronounced dead, the medical paediatric or A&E consultant or delegated senior clinician should inform the parents, having first reviewed all the available information. S/he should explain future police and Deputy Viscounts (or Coroner) involvement, including the Deputy Viscounts authority to order a post-mortem examination. This may involve taking particular tissue blocks and slides to ascertain the cause of death. The medical consultant must seek consent from those with parental responsibility for the child if the tissue is to be retained beyond the period required by the Deputy Viscount. All of this is covered in the Post Mortem Guide. A copy of this should be passed to the family and the family taken through the guide by the appointed FLO or other professional involved.

3.13 The parents 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.

3.14 The medical consultant who saw the child must inform the on call paediatrician or equivalent, immediately after the Deputy Viscount is informed. The Deputy Viscounts office (or Coroner) must investigate violent or unnatural death, or death of no known cause and all deaths were a person is in custody at the time of the death. The Deputy Viscounts (or Coroner) must have jurisdiction over the child's body at all times.

3.15 The same processes will apply to a child who is admitted to a hospital ward and subsequently dies unexpectedly in hospital.

3.16 Professionals should be aware that, in certain circumstances, separate processes may be taking place alongside those described in this procedure (i.e. murder investigations, SUDI processes etc).

**Immediate notification and information sharing**

3.17 The Designated paediatrician or equivalent, is responsible for co-ordinating the multi-agency response, and must ensure that the following have been notified:

- The Deputy Viscount;
- The police; and
- Other agencies as appropriate (e.g. children's social care).

And, in a timely manner, will notify the Chair of the SPB.

3.18 The Designated paediatrician or equivalent, must ensure that information is shared and initiate a planning discussion between relevant agencies such as the police, health and children's social care (and others, including the Deputy Viscounts office) in a timely manner to decide next steps. This may or may not involve a meeting.

3.19 Where the death occurred in a hospital, the plan should also address the actions required by the hospitals serious incidents protocol. Where the death occurred in a custodial setting, the plan should ensure appropriate liaison with the investigator from the Prison's Ombudsman.

3.20 Before leaving the hospital, or if the child died at home, before the professionals leave the home, the parents have the contact details for the lead professionals (consultant paediatrician, senior investigating police officer or Dep Viscount), and the details of who they should contact for information on the progress of any investigation or if they wish to visit the hospital to see their child. This function will generally be fulfilled by a Police Family Liaison officer.

3.21 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 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. The enquiries should be made in conjunction with the Deputy Viscounts office.

**Police investigation**

3.22 The police will begin an investigation into the unexpected death of a child on behalf of the Deputy Viscount.

**Potential visit to the place where the child died**

3.23 When a child dies unexpectedly in a non-hospital setting the senior investigating police officer and Designated paediatrician or equivalent, should make a decision about whether a visit to the place where the child died should be undertaken and who should attend. This should almost always take place for cases of sudden infant death (Working together) (SUDI) - *[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] [See paragraph 5.1 in the Kennedy Report]*

**Phase II: within 5 - 7days**

3.24 A case discussion should take place 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, and refer accordingly to the police child protection team and children's social care;

- 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) for doing so. If abuse or neglect appear to be possible causes of death, children's social care and the police should be informed and serious case review procedures considered.

3.25 Prior to this meeting, the Designated paediatrician or equivalent, should discuss the case with the pathologist (when a post-mortem has taken place and consent obtained from the Deputy Viscount) and the police senior investigating officer, where appropriate.

**Involvement of the Deputy Viscount (or coroner) and pathologist**

3.26 If s/he deems it necessary (and in almost all cases of an unexpected child death it will be), the Deputy Viscount 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 or equivalent, should collate information collected by those involved in responding to the child's death and share it with the

pathologist conducting the post mortem examination in order to inform this process. Where the death may be unnatural, or the cause of death has not been determined (and in other certain circumstances), the Deputy Viscount will in due course hold an inquest.

3.27 All information collected relating to the circumstances of the death - including a review of all relevant medical, social and educational records - must be included in a report for the Deputy Viscount prepared by the Police. Evidence and information obtained should be provided to the Deputy Viscount as soon as it is available and as soon as possible. In the usual way, an initial Police Sudden death report should be made available to the Deputy Viscount as soon as possible, other reports from professional agencies should be delivered to the Deputy Viscount within 28 days of the death, unless some of the crucial information is not yet available.

3.28 The results of the post mortem examination belong to the Deputy Viscount. In most cases it is possible for these to be discussed by the paediatrician and pathologist, together with the senior investigating police officer, as soon as possible, and the Deputy Viscount should be informed immediately of the initial results.

3.29 If the initial post-mortem findings or findings from the child's history suggest evidence of abuse or neglect as a possible cause of death, the police and children's services should be informed immediately, and the serious case review

processes in **Serious Case Reviews Procedure** should be followed. If there are concerns about surviving children living in the household, professionals should follow the procedures set out in **Child protection enquiry** below.

3.30 In all cases, the designated paediatrician or equivalent, for unexpected child deaths or the Designated paediatrician or equivalent, should convene a further multi-agency discussion very shortly after the initial post-mortem results are available. This discussion usually takes place five to seven days after the death and should involve the pathologist, police, local authority children's social care and the paediatrician, plus any other relevant healthcare professionals, to review any further information that has come to light and that may raise additional concerns about safeguarding issues.

**Phase III: usually within 8 - 12 weeks**

3.31 Further case discussion meeting should be convened and chaired by the Designated paediatrician or equivalent, following the final results of the post-mortem examination becoming available. This should involve those who knew the child and family and those involved in investigating the death - the GP, health visitors, school nurse, paediatrician/s, pathologist or pathologist report, police senior investigating officers and, where relevant, social workers.

3.32 The purpose of the meeting is to share information to

identify those factors that may have contributed to the death and then to plan the future care for the family. Potential lessons to be learned may also be identified at this stage. The outcome of this meeting should inform the inquest, if there is one.

3.33 The meeting 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.

3.35 The Designated paediatrician or equivalent must ensure that the results of the post-mortem examination are shared with parents, provided this is consistent with the requirements of the Deputy Viscount and the police.

3.36 Where other investigations are ongoing, the meeting should conclude with a record of the current situation.

3.37 An agreed record of the case discussion meeting and all reports should be sent to the Deputy Viscount, to take into consideration in the conduct of the inquest.

## 4. Other related processes

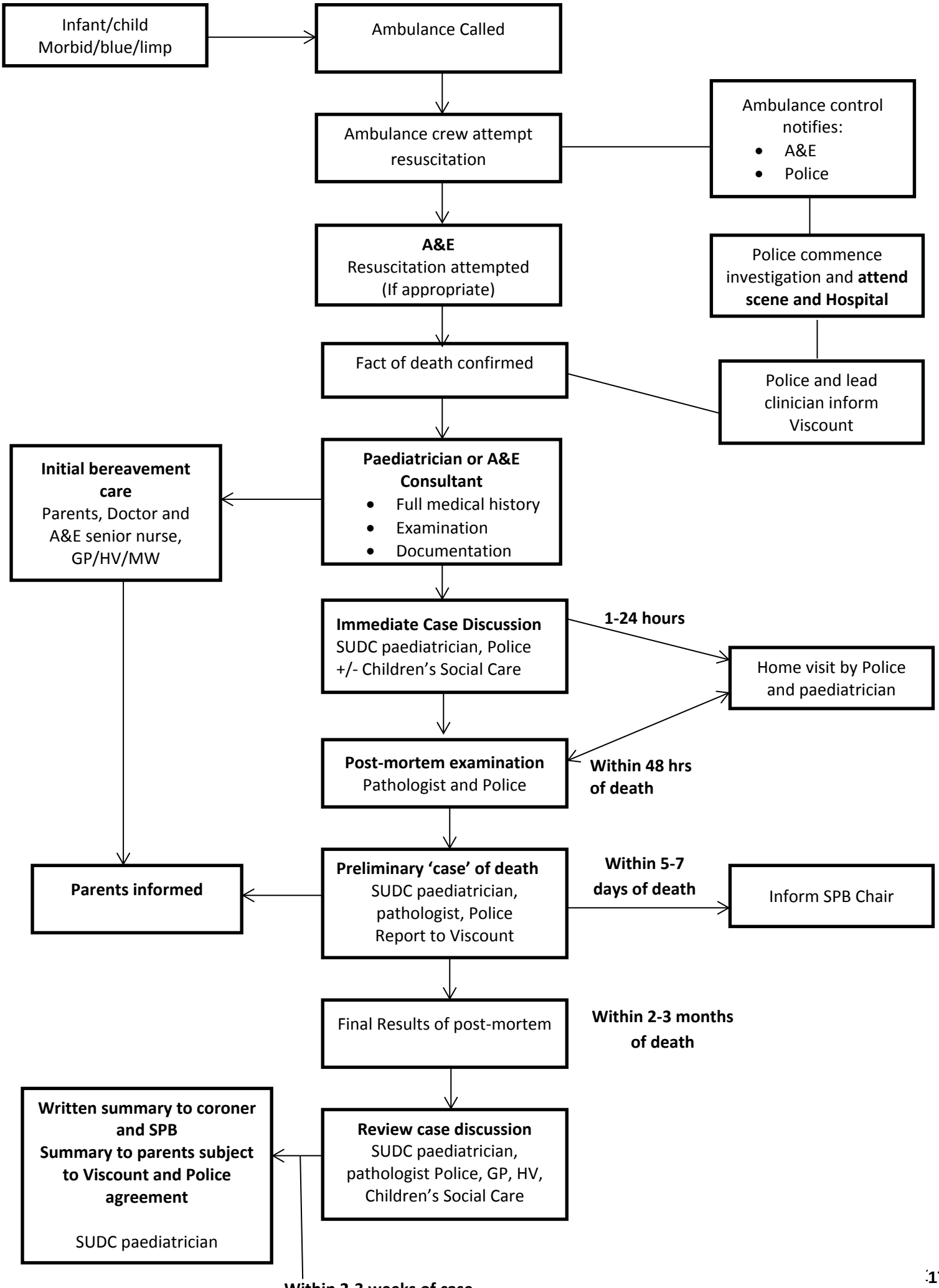
4.1 If, during the enquiries, concerns are expressed in relation to the needs of surviving children in the family, discussions should take place with Children's Services. It may be decided that it is appropriate to initiate an initial assessment.

If concerns are raised at any stage about the possibility of surviving children in the household being abused or neglected, the multi-agency guidelines should be followed. Children's Services have lead responsibility for safeguarding and promoting the welfare of children. The police will be the lead agency for any criminal investigation. The police must be informed immediately that there is a suspicion of a crime, to ensure that the evidence is properly secured and that any further interviews with family members are conducted if appropriate.

4.2 If it is thought, at any time, that the criteria for a serious case review might apply, the Chair of the SPB should be contacted and the serious case review procedures should be followed.

4..3 Where there is an ongoing criminal investigation, the Senior Investigating Officer and the Law Officer's Department must be consulted as to what it is appropriate for the professionals involved in reviewing a child's death to be doing, and what actions to take in order not to prejudice any criminal proceedings.

In certain circumstances a second post mortem examination may be required by a Defendant in criminal proceedings or at the insistence of the family of the deceased child.


Infant/child
Morbid/blue/limp
Ambulance Called
Ambulance crew attempt resuscitation
Ambulance control notifies:
A&E
Police
A&E
Resuscitation attempted
(If appropriate)
Police commence investigation and attend scene and Hospital
Fact of death confirmed
Police and lead clinician inform Viscount
Initial bereavement care
Parents, Doctor and A&E senior nurse, GP/HV/MW
Paediatrician or A&E Consultant
Full medical history
Examination
Documentation
Immediate Case Discussion
SUDC paediatrician, Police +/- Children's Social Care
1-24 hours
Home visit by Police and paediatrician
Post-mortem examination
Pathologist and Police
Within 48 hrs of death
Parents informed
Preliminary 'case' of death
SUDC paediatrician, pathologist, Police
Report to Viscount
Within 5-7 days of death
Inform SPB Chair
Final Results of post-mortem
Within 2-3 months of death
Written summary to coroner and SPB
Summary to parents subject to Viscount and Police agreement
SUDC paediatrician
Review case discussion
SUDC paediatrician, pathologist Police, GP, HV, Children's Social Care
Within 2-3 weeks of case