London Rapid Response Procedure

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Contents

Acknowledgement

The London Safeguarding Children Board thanks Harrow Safeguarding Children Board and the Metropolitan Police for providing the basis for this procedure.

1. Introduction

1.1 This procedure sets a minimum standard for a rapid response service for unexpected deaths in infancy and childhood as outlined in chapter 7 of the Government guidance *Working Together to Safeguard Children (DCSF, 2006)*.

1.2 The aim of the procedure is to ensure that the response is safe, consistent and sensitive to those concerned, including ensuring that bereaved parents and siblings receive similar approaches across London.

1.3 This procedure applies when a child dies unexpectedly (birth up to 18th birthday, excluding babies stillborn), or where there is a lack of clarity about whether a death of a child is unexpected.

1.4 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.

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

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 Actions assigned to the designated paediatrician for child death (DP) can be delegated to a nominated senior healthcare professional unless specifically stated otherwise. This person will be referred to in this procedure as the 'DP or equivalent'.

1.8 The DP, following consultation with the lead clinician, is responsible for making the final decision on whether a death is unexpected. An interim decision may be made by the nominated healthcare professional when the DP is unavailable (e.g. on leave, unwell etc), but this must be reviewed by the DP on their return. This final decision cannot be delegated, and must be recorded with clear reference to who was involved in the discussion.

1.9 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.

1.10 At a national level, the DCSF have developed a number of templates for LSCBs to use to assist collecting information about child deaths: Form A for initial notification, Form B (1-11) for agency reports, Form C for analysis at the panel meeting, Form D for rapid response auditing and Form E for child death overview panel auditing.

1.11 LSCB Chairs in London have agreed that London will use the Forms B - E. These are available to download from http://www.ecm.gov.uk/search/TP00045/, and Forms B and D are included as appendices to this procedure (see appendix 6b. National templates).

However, for initial notification London will use the initial notification form available at www.londonscb.gov.uk/child_death and appendix 6a. This is in place of the DCSF Form A.

2. Terms and remit

Rapid response service

2.1 The purpose of rapid response 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 (see appendix 4 for services available from Cruse Bereavement Care);
- 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 coroner when required;
- Enquire and constructively challenge how each organisation discharged their responsibilities to an individual child's death, and whether there are any lessons to be learnt;
- Collate information in a standard format (see DCSF Form B in appendix 6b for details of national templates for LSCBs to use when collecting information about child deaths)
- 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;
- Consider bereavement support for any other children, family members or members of staff who may be affected by the child's death.

See appendix 2. Key strands to rapid response for more information.

2.2 Rapid response begins at the point of death and ends when the final meeting has been convened and chaired by the DP or equivalent. Any records of the meeting (i.e. DCSF Form B / meeting notes) should be forwarded to the CDOP at the time of the review.

2.3 The area in which the death of a child has been declared must take initial responsibility for convening and co-ordinating the rapid response process, until agreement for handover can be secured with the area where the child is normally resident. See point 7.3 in the *London Child Death Overview Panel Procedure (London Board, 2009)* for information around conflict resolution in cases where it is unclear where the child normally resided.

2.4 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.

2.5 The rapid response timeline (involving three phases) is described in appendix 1. The DP or equivalent is responsible for ensuring all actions relating to the rapid response process are completed.

Single Point of Contact (SPOC)

2.6 LSCBs must arrange for a single point of contact (SPOC) to be available during working hours, to be informed of all child deaths and to assist in initiating the multi-agency rapid response service. A list of all London SPOCs is available at www.londonscb.gov.uk/child_death/spoc/.

2.7 Out of hours, rapid response processes must be instigated by the responsible on call professionals as required and reported to the SPOC on the next working day. The London notification form (available at appendix 6a) must be completed and forwarded to the SPOC immediately at time of death.

Appendix 1: Rapid response timeline

1.1 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.

See also Rapid Response Flowchart in appendix 3.

1.2 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.

2 Phase I: usually 0 – 5 days

Immediate response:

2.1 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.

2.2 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), 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 (see DCSF information sheet: Deaths in Children with Life-Limiting Conditions)[1].

2.3 Where a child is not taken immediately to A&E, the professional confirming the death should inform the coroner, SPOC and the DP or equivalent at the earliest opportunity.

On arrival at hospital

2.4 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. The information should be collated using the *DCSF Form B (see appendix 6b for details)*.

2.5 Where the cause of death or factors contributing to it are uncertain, investigative samples should be taken immediately on arrival and after the death is confirmed. These need to be agreed in advance with the coroner and should include those

[1] http://childdeath.ocbmedia.com/public_docs/Information%20Sheet%20-%20Deaths%20in%20Children%20with%20Life-Limiting%20Conditions.pdf

listed in Table 1 of *Sudden Unexpected Death in Infancy (Royal College of Pathologists and Royal College of Paediatrics and Child Health, 2004)*[2]. Other samples may be required as guidance evolves. Consideration should always be given to undertaking a full skeletal survey, and if this is appropriate it should be done prior to autopsy.

2.6 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 coronial involvement, including the coroner's 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 coroner.

2.7 The medical consultant who saw the child must inform the DP or equivalent immediately after the coroner is informed.

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

2.9 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

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

- The coroner;
- The police;
- Other agencies as appropriate (e.g. LA children's social care);

And, in a timely manner, will notify:

- The Child Death Overview Panel (using the appropriate Form B, see appendix 6b)
- The Director of Public Health

2.11 The DP or equivalent must ensure that information is shared between relevant agencies such as the police, health and LA children's social care in a timely manner to decide next steps. This may or may not involve a meeting.

2.12 The DP or equivalent is also responsible for initiating the information gathering and sharing and planning discussions, and should ensure that the child's parents / carers have been informed and that support is available to them.

2.13 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. If a young person is under the supervision of a Youth Offending Team (YOT), the YOT should also be approached.

[2] http://www.rcpath.org/resources/pdf/SUDI%20report%20for%20web.pdf

Potential visit to the place where the child died

2.14 A decision must be made about 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. The professionals responsible for the decision are the investigating police officer and the DP or equivalent. For all children aged 2 years and under, the local SUDI protocol must be followed.

2.15 As well as deciding if the visit should take place, it should be decided how soon within the 24 hours it should take place, and who should attend. This will be a matter for professional judgement and agreement.

2.16 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. These visits can also provide support to the family as part of their bereavement process

3 Phase II: within 5 – 7days

3.1 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 LA children's social care;
- ensure agencies are collating information for the DCSF Form B (see appendix 6b);
- 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, LA children's social care and the police should be informed and serious case review procedures considered.

3.2 Prior to this meeting, the DP or equivalent 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

4 Phase III: usually within 8 – 12 weeks

4.1 A further case discussion meeting should be convened and chaired by the DP 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, coroner or coroner's officer and, where relevant, social workers.

4.2 The purpose of the meeting is to share information to identify the cause of death and/or 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 will inform the inquest, if there is one.

4.3 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.

4.4 The meeting should agree how the parents will be informed about the outcome of the meeting and how they will be provided with on-going support, including how the parents will be given the opportunity to have their views taken into account by the CDOP review.

4.5 The DP 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 coroner and the police.

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

4.7 Any records of the meeting (i.e. DCSF Form B / meeting notes) should be forwarded at the time of the review to the CDOP for the area where the child normally resided at the time of death.

Appendix 2: Key strands to rapid response

1.1 The seven key strands to rapid response are:

1) Care of the bereaved family:

Ensuring at every phase that the needs of the bereaved family are of paramount consideration to any professional involved with a family where a child is dying or has died. This includes the welfare and protection of remaining siblings, spiritual needs and possible involvement of the extended family (see appendix 4 for more details).

2) Deciding on response:

Deciding on whether the death is unexpected and whether to implement the rapid response procedure. The designated paediatrician responsible for unexpected deaths in childhood is responsible for making the decision about whether a death is unexpected.

3) Notification to the Single Point of Contact (SPOC):

The SPOC will be notified of all child deaths by the professional confirming the fact of death, using the notification form (see Notification proforma in appendix 6a). This will remain the responsibility of the professional confirming the fact of death until s/he is able to hand over to the DP. Notification must be made within 24 hours in order for the rapid response to commence.

Depending on local arrangements, the SPOC / DP or equivalent will initiate a phase II meeting or discussion.

4) Child protection:

Emerging information giving rise to child protection concerns about remaining siblings and/or other children in the household or peer group must take priority and will require formal referral to LA children's social care in line with *section 6. Referral and assessment*, in the *London Child Protection Procedures (LSCB, 2007)*. See also *section 5. Children in specific circumstances*, *London Child Protection Procedures (LSCB, 2007)*.

5) Serious case review:

All agencies need to be mindful of any emerging information giving rise to the need for the LSCB to consider conducting a serious case review in line with *section 19. Serious case reviews* of the *London Child Protection Procedures (LSCB, 2007)*[3]. A review of this nature would be conducted using chapter 8 of *Working Together* and will operate simultaneously to the rapid response procedure.

The decision to undertake a serious case review must be taken by the Chair of the LSCB where the child normally resided.

[3] *Section 19. Serious case reviews,* of the *London Child Protection Procedures (LSCB, 2007)* is in accordance with *Chapter 8* of government guidance *Working Together to Safeguard Children (DCSF, 2006)*.

6) Media issues:

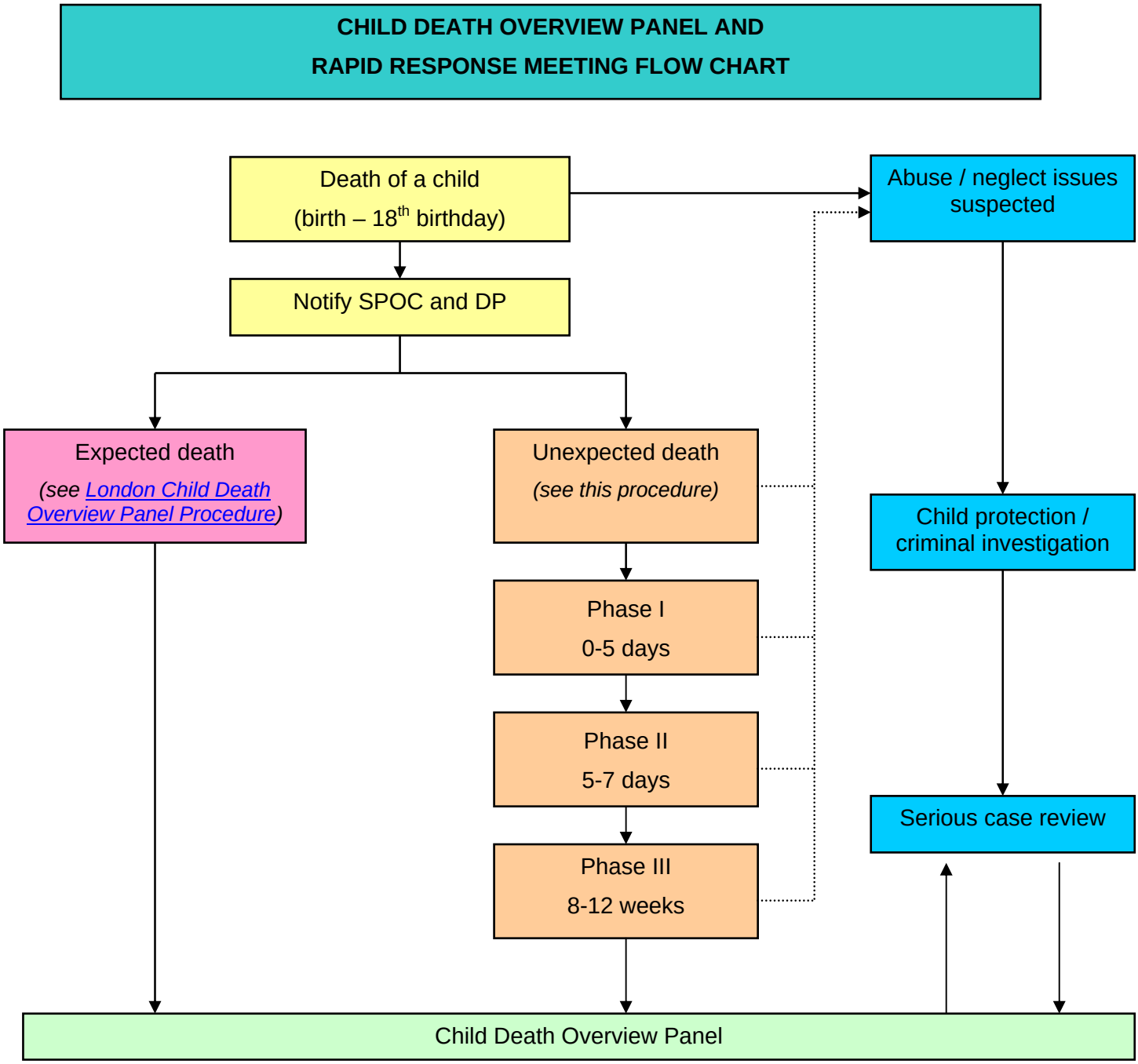
All Local Safeguarding Children Boards should have a process for managing media interest. Staff must be enabled to proceed with their functions without intrusion and the family provided with privacy.

Media attention and enquiries will be managed by the Local Safeguarding Children Board in collaboration with the Metropolitan Police press office.

7) Support to staff:

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.

Appendix 3: Rapid response flowchart



Appendix 4: Services available from Cruse Bereavement Care

- On-line access to information at www.cruse.org.uk
- Confidential Day-by-Day Helpline 0844 477 9400 and email helpline: helpline@cruse.org.uk
- Free leaflets available though the helpline, the website, and from local branches or from Cruse central office
- Individual face-to-face bereavement support from a Bereavement Volunteer
- For young people, on-line access to information, forums and support at www.rd4u.org.uk
- For young people, a freephone helpline 0808 808 1677 and private email service through www.rd4u.org.uk
- Support in a bereavement group.

Appendix 5: Designated paediatrician for unexpected deaths in childhood

1.1 This role is described in *Working Together to Safeguard Children*, chapter 7, paragraph 7.18 and involves:

- Leading the co-ordination of multi-agency activity and information sharing throughout the rapid response process;
- Ensuring all agencies are notified and actions are agreed, with support from their SPOC;
- Ensuring a case discussion or meeting takes place, normally within 5-7 days of the death;
- Ensuring a formal case discussion or meeting takes place, normally 8-12 weeks following the death although this may be predicated by post mortem or other investigations; and
- Ensuring that a full and accurate report is provided to the Local Safeguarding Children Board's Child Death Overview Panel (using the child death information gathering and evaluation booklet, and additional papers as appropriate).

1.2 Actions assigned to the designated paediatrician for child death (DP) can be delegated to a nominated senior healthcare professional unless specifically stated otherwise. This person will be referred to in this procedure as the 'DP or equivalent'.

1.3 The DP, following consultation with the lead clinician, is responsible for making the final decision of whether a death is unexpected. This decision cannot be delegated, and must be recorded with clear reference to who was involved in the discussion.

Appendix 6a: Notification to the designated paediatrician for unexpected deaths in childhood and the LSCB of a child's death

Working Together to Safeguard Children (DfES, 2006 - WT) chapter 7 sets out a statutory requirement for the Local Safeguarding Children Board to review the deaths of all children up to their 18th birthday.

Section 7.51 (WT) states that the LSCB should be informed of all deaths of children normally resident in the LSCB's geographical area. The CDOP single point of contact (SPOC) should be notified of all child deaths in their area, or of children normally resident in the area but who die elsewhere, and will then notify the CDOP members, who act on behalf of the LSCB.

Local agencies responding to a child's death as well as informing the coroner, if needed, should inform the DP or equivalent for the LSCB area using the attached proforma. Information can be conveyed in a confidential telephone conversation but there should be agreement during this call as to who will take responsibility for completing the attached written notification proforma. Where the information is passed by telephone it will be helpful for both parties to have a copy of the proforma in front of them while talking to assist the sharing of information.

The information should be treated in strictest confidence.

Designated paediatricians:

[insert name of Local] Safeguarding Children Board	Fax:	Tel:
[insert name of Local] Safeguarding Children Board	Fax:	Tel:

Etc.

The written Notification proforma should be completed as fully as possible and sent the same day. For deaths which occur after 5pm, at weekends or on bank holidays, the written Notification proforma should be sent by 10am the next working day.

It is best practice to seek consent before processing information about any individual, but it will be legitimate to share information with the designated paediatrician for unexpected deaths in childhood/the LSCB SPOC without seeking parental consent. It should only be shared with those who need to know as governed by the Caldicott Principles, the *Data Protection Act* and *Working Together 2006*. Persons with parental responsibility *(Children Act 1989)* should be advised that the child's death will be subject to a review in order to learn any lessons that may help to prevent future deaths of children. This must be handled sensitively. There is a LSCB leaflet available to assist parents and others with parental responsibility in understanding the review process and how they can contribute (see www.londonscb.gov.uk/child_death/). This would normally be done by the paediatrician confirming the child's death to the parents.

A death that is unexpected[4] may require a **rapid response** or a specific review of circumstances or an unexpected child death meeting as set out in the *London Child Protection Procedures section 12* [5]. It will be the responsibility of the designated paediatrician for unexpected deaths in childhood (or delegate) and senior police officer in the case to agree the process that such a response will take. This will often involve other agencies, e.g. LA children's social care, LA education, mental health services etc.

[4] ' … defined as a death of a child (birth to 18 years, excluding babies stillborn) which was 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 which led to the death'. London Child protection Procedures 2007 Section 12.1.1

[5] ***London Child Protection Procedures*** – every agency must ensure that staff have access to a copy – they can also be accessed at www.londonscb.gov.uk/procedures

Initial notification of the death of a child – to be completed as fully as possible within 24 hours. Please complete in BLOCK CAPITALS.
DO NOT DELAY

Family name of child				First and other names of child	
Date and time of death				Date of birth of child	
Ethnicity of child		Sex of child		Carer of child at time of death	
Name/s of persons with parental responsibility i.e. mother, father or other (state relationship)					
Home address of child				Post code	
GPs name		GP address and postcode			
Other children in household or affected by the death (please complete with any available information)	Names (if known)			Ages / DOB (if known)	
Place / locality of death				Contact number	
Senior medical practitioner present at time of death				Contact number	
Is this an unexpected death? i.e. not expected in the previous 24 hours	YES NO	Has this been confirmed by the designated doctor for child death?	YES NO	Is a post-mortem required?	YES NO
Summary description of the circumstances of the death					
PRINT name		Organisation			
Signature		Date and time of notification			

Please fax the form to the relevant LSCB Single Point of Contact (SPOC)
(see **www.londonscb.gov.uk/child_death/spoc/** for contact details)
The fax should be marked STRICTLY CONFIDENTIAL

Initial notification Unique Reference Number (e.g. KG/08/0001) – to be completed by SPOC on receipt of this form	

Initial notification Unique Reference Number

The table contains identification codes used by the police for the 32 London LSCB areas, which will also be used as the Unique Reference Number for each CDOP area.

The suggested format for each Single Point of Contact to use from 1st April 2008 will be to use the code followed by the year and then a sequential number using four spaces. Thus the first report of a death of a child in Barking & Dagenham would be recorded as **KG/08/0001.**

Alphabetical Boroughs List of Codes

Borough	Code	Borough	Code
Barking & Dagenham	KG	Hounslow	TX
Barnet	SX	Islington	NI
Bexley	RY	Kensington & Chelsea	BS
Brent	QK	Kingston upon Thames	VK
Bromley	PY	Lambeth	LX
Camden	EK	Lewisham	PL
Croydon	ZD	Merton	VW
Ealing	XB	Newham	KF
Enfield	YE	Redbridge	JI
Greenwich	RG	Richmond upon Thames	TW
Hackney	GD	Southwark	MD
Hammersmith & Fulham	FH	Sutton	ZT
Haringey	YR	Tower Hamlets	HT
Harrow	QA	Waltham Forest	JC
Havering	KD	Wandsworth	WW
Hillingdon	XH	City of Westminster	CW

Appendix 6b: National templates for LSCBs to use when collecting information about child deaths

The following national data collection templates are available to download online at http://www.everychildmatters.gov.uk/resources-and-practice/TP00045/:

- Form B Agency Report
  - Form B2 - Road Traffic accident
  - Form B3 – Drowning
  - Form B4 - Fire and Burns
  - Form B5 - Poisoning
  - Form B6 - Other non-intentional injury
  - Form B7 - Substance misuse
  - Form B8 - Apparent homicide
  - Form B9 - Apparent suicide
  - Form B10 - Sudden unexpected death in infancy
  - Form B11 - Summary of post-mortem findings
- Form C Analysis proforma
- Form D Audit tool for rapid response
- Form E Audit tool for child-death overview