Bath and North East Somerset
Local Safeguarding Children Board

RAPID RESPONSE PROCESS

2008

Process for responding to a child death in Bath and North East Somerset: the Rapid Response Team

1. Introduction

1.1 The procedure for responding to child deaths is set out in Chapter 7 of Working Together to Safeguard Children 2006.

1.2 Within this guidance, there is a distinct process for responding to *unexpected* child deaths within the LSCB area which is the *Rapid Response* process.

1.3 This procedure should be followed when a decision has been made that the death is unexpected and when there is a lack of clarity as to whether the death is unexpected.

1.4 The aim of this procedure is to ensure that the response to unexpected child deaths is coherent and co-ordinated, with those involved clear as to the purpose of the process, and their role and others roles within it.

Definition of an unexpected child death

Working Together 2006 defines an unexpected child death as a death of a child up to 18 years that 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 that led to the death.

2. Rapid Response Process

2.1 The rapid response process is a process of communication, collaborative action and information sharing following an unexpected death.

2.2 The purpose of the Rapid response is to ensure that the relevant agencies work together effectively, share information and support the family appropriately and;

- Respond quickly to the unexpected child death
- Make immediate inquiries into and evaluate the reasons for and circumstances of the death, in agreement with the coroner
- Undertake the type of enquiries that relate to individual agency responsibilities when a child dies unexpectedly
- Collect information as per the agreed process, either as part of the initial planning meeting, Strategy Meeting or both.
- Consider the support required for the parents and sibling and ensure effective bereavement support, including maintaining contact at regular intervals with family members, ensuring they are kept informed with information about the child's death.

2.3 The Rapid response process begins at the point of death and ends with the report to the West of England Child Death Overview Panel, compiled by the paediatrician involved, following the final case

discussion meeting of the Rapid Response Team, which will include information from the post mortem examination and other relevant information.

3. Process of Rapid Response

There are three parts of the Rapid Response process –

a. Immediate management
b. Early Management
c. Later Management

a. Immediate management

First professional on the scene

3.1 If the first professionals on the scene are not medical professionals, then they must ensure urgent medical assistance as a priority. The ambulance service or doctor must not assume death, but initiate/continue resuscitation unless clearly inappropriate.

Where the child is not taken immediately to the Emergency department, the professional confirming the fact of death should inform the Designated Paediatrician with responsibility for unexpected deaths in childhood.

3.2 The police should be notified if not already present and the Avon Ambulance Service called to take the child/young person to the nearest Emergency department.

3.3 As part of the Rapid Response process the Ambulance service will *always* take a child to the emergency department of the appropriate hospital unless there is good reason not to i.e. if the body is required to remain at the scene for forensic examination.

3.3 The Doctor in charge at the emergency department (which may be the Designated Paediatrician) will co-ordinate resuscitation attempts and decide when to cease resuscitation attempts, and pronounce the child deceased. The Doctor will notify the SUDI/SUDC Paediatrician on call, who will agree attendance and be responsible for notifying the Police, Social Care/EDT and Coroner.

4. Designated paediatrician for unexpected deaths in childhood (SUDI/SUDC Paediatrician)

4.1 The role of the Designated Paediatrician is described in Working Together to Safeguard Children 2006. It involves –

- Notifying the Single Point of contact of the death **– The notification number is:** 0117 928 5151 where the details of a child's death can be left on the answer phone for CEMACH to process accordingly.

  Where the child normally resident in another area dies within the locality, that death should be notified to the CDOP in the child's area of residence. Similarly when a child normally resident in the locality dies elsewhere, the West of England CDOP should be notified.

  There is also a **notification form** to be completed (attached) and available from the every child matters website http://www.everychildmatters.gov.uk/resources-and-practice/TP00045/ in as much detail as possible at the time, but this should not delay the sending of the information.

  This should then be sent to Rosie Thompson at; rosie.thompson@nhs.net.

- Notifying the relevant agencies, including the coroner, if the death
- Co-ordinating the work of the Rapid Response Team
- Bringing together the Rapid Response Team at various points to consider the information regarding the circumstances of the death, plan the investigation, consider any child protection issues, support for the family and
- Provide a full and accurate report at the end of the process following the outcome of the post mortem/autopsy for the Child Death Overview Panel (see above for which CDOP).

4.2 The Paediatrician will agree the timing of the visit to the hospital/parents with the police, and arrange with medical staff the documentation of initial findings and interventions, examination of the child, initial support for parents and initial history taking by police and Paediatrician.

4.3 The Paediatrician will also agree with the Coroner any other samples, specimens to be taken that may be necessary

4.4 The Paediatrician is responsible for deciding whether a death was unexpected.

b. Early management

5.1 A multi-agency planning meeting, co-ordinated by the Paediatrician should be called within a few hours of the death. It should involve the Police, Social care and Emergency Dept. staff and Paediatrician as a minimum.

5.2 Information shared will include the available information and reports, identify what other information is required and how and when and by whom it will be obtained. There should also be consideration of any

child protection concerns and implications for other children AND whether a Strategy Discussion is required.

5.3 **Where there are no CP concerns** and no need for a Strategy discussion, it will be the expectation that the Paediatrician is responsible for notes from the meeting and that these are made available in a timely fashion to allow for the relevant investigations/information gathering to take place.

5.4 The purpose of this meeting will be to plan the process of the investigation into the child's death; agree roles and responsibilities, including joint scene visit; post mortem examination, notifying relevant services; what information to share with and support for the family and who will do this.

5.5 There will also be a need to agree statutory and forensic requirements, including scene security and preservation of evidence.

5.6 The Referral and Assessment Team will open a referral on the child.

5.7 **Where there are CP concerns** and a Strategy Meeting is required, there needs to be formal agreement of this and the meeting will become a Strategy discussion, with the normal CP process commencing at from that point. The SW manager attending will become responsible for chairing and taking/circulating minutes of the Strategy as per the agreed process. In addition to decision making as part of the Strategy discussion, the meeting would also need to agree the process of investigation set out in 5.4 above

5.8 Review – due to the nature of the Rapid Response process and the various investigations and information gathering that may need to take place, an investigation may take a number of months to complete, or longer.

There should be an agreement at the initial meeting as to when the Rapid Response team will come back together to review any new information that may impact upon the process of the investigation (particularly if child protection concerns are uncovered during the course of the investigation). This will allow for review and further planning in a co-ordinated way. It may be necessary for a number of review meetings to take place, depending on the nature of the case. The Paediatrician will be responsible for co-ordinating these, unless the child protection process has been initiated in which case the Social Care manager will co-ordinate these.

5.9 The CP and RR process will run in parallel and the CP process will not be a substitute for the RR process, but one will inform the other and vice versa.

6. Home Visit

6.1 As part of the planning meeting arrangements for the home visit would be agreed, which would normally involve the Police and Paediatrician but may also include other professionals where relevant. The home visit should take place within a few hours of the death and evidence/information gathered according to the agreed guidance. Where a child dies outside the home, consideration of who should visit the scene will need to be considered.
Any information to be shared with the parents will need to be agreed with the Coroner and other professionals as appropriate.

7. Autopsy

7.1 The police will send a report of their findings to the Coroner, who will order an autopsy if they are unable to satisfy themselves that the death was due to natural causes. This will be held as soon as possible after the death.

Depending on the outcome of this, the Coroner may order further investigations and may order an Inquest into the death.

c. Later management

Further investigations and inquiries may include preliminary and final autopsy report, special medical investigation, further police inquiries and a review of previous records.

8. Case Discussion and Review

8.1 Although the Inquest will not yet have been carried out, a Review of all the information gathered as part of the investigation should take place, which could occur 2-3 months after the death, depending on the circumstances. The Review will inform the Inquest. The Paediatrician would be responsible for co-ordinating this and gathering the RR team together to consider the information.
The Purpose of the meeting will be to review all the information from the history, scene investigation; post-mortem findings; identify cause of death (if possible at this stage) and any CP issues; identify any ongoing needs of the family; consideration of feedback to the family, including the needs of any other children; support for the professionals involved and any wider lessons to be learned.

8.2 The Paediatrician should provide a report of the case discussion for the RR team members and send a copy of this to the Child Death Overview Panel via the University of Bristol (CEMACH).

Process for responding to a child or young person from B&NES who dies.

1. **Children in B&NES who die in another Local Authority**
    - **Police** – in the day the Police in the area *where the incident occurred* will respond. After hours the Police Sergeant on call will attend if the incident occurs in B&NES, Bristol or South Gloucester. If the Incident occurs in Authorities other than this including North Somerset, that police force will respond. B&NES CAIT would expect however to be notified and may take the view to be involved where this makes sense.
    - **Social Care** – where the *child lives in B&NES and the incident occurs elsewhere* or the child is taken to a hospital out of the area, Social Care from B&NES would normally respond, except where distance would prevent them from responding according to the RR guidance. They would however want to be flexible in their approach and where the family is known Social Care would want to be involved at the earliest stage.
    - **Paediatrics** – The Paediatricians operate a duty rota for the B&NES, Wiltshire and North Somerset area. They would respond to any child from those areas when on duty, but there will be some flexibility in this, where a child is well known to a particular paediatrician and they are available even if not on duty.

      Where a child from B&NES is taken to another hospital outside of the 3 areas above, it would be the expectation in principle that the paediatrician on duty in that area who would lead the RR team, however again, this requires a degree of flexibility, due to timing and potential distance involved. The paediatricians would consider each case individually and where it makes sense for them to lead would do so.

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