Wiltshire and Swindon
Joint Agency Response (JAR) and Child Death Protocol for Unexpected Deaths

Introduction

A coordinated multi-agency response (on-call health professional, police investigator, duty social worker), should be triggered if a child's death:

- Is or could be due to external causes;
- Is sudden and there is no immediately apparent cause (including SUDI/C);
- Occurs in custody, or where the child was detained under the Mental Health Act;
- Where the initial circumstances raise any suspicions that the death may not have been natural; or
- In the case of a stillbirth where no healthcare professional was in attendance.

The full process for a Joint Agency Response is set out in the national Sudden Death in Infancy/Childhood: multi-agency guidelines for care and investigation (SUDI/C) Guidelines which build on the statutory requirements for child death review set out in Chapter 5 of *Working Together 2018*.

- This Wiltshire and Swindon joint agency response and child death protocol for unexpected deaths 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 2018.

- 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 Joint Agency Response and Local Case Discussion (LCD) 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 (employed by Virgin Care) who will co-ordinate and lead the Joint Agency Response process including the Joint Agency response meeting and Local Case Discussion. . A Consultant Community Paediatrician will be on-call from 8am – 8pm Monday – Friday, and 9am – 5pm Saturday and Sunday. Outside of these hours an Acute Paediatric Consultant is on-call.

- 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 Joint Agency response meeting(s). The Designated Doctor will co-ordinate and lead the Local Case Discussion.
- 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 Joint Agency response meeting(s). The Designated Doctor for Child Death will co-ordinate and lead the Local Case Discussion.

- For children from other parts of Wiltshire and those in Swindon, home visits are currently undertaken by health responders including school nurses, health visitors or Doctors. Health responders should be invited to and attend the Joint Agency 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).

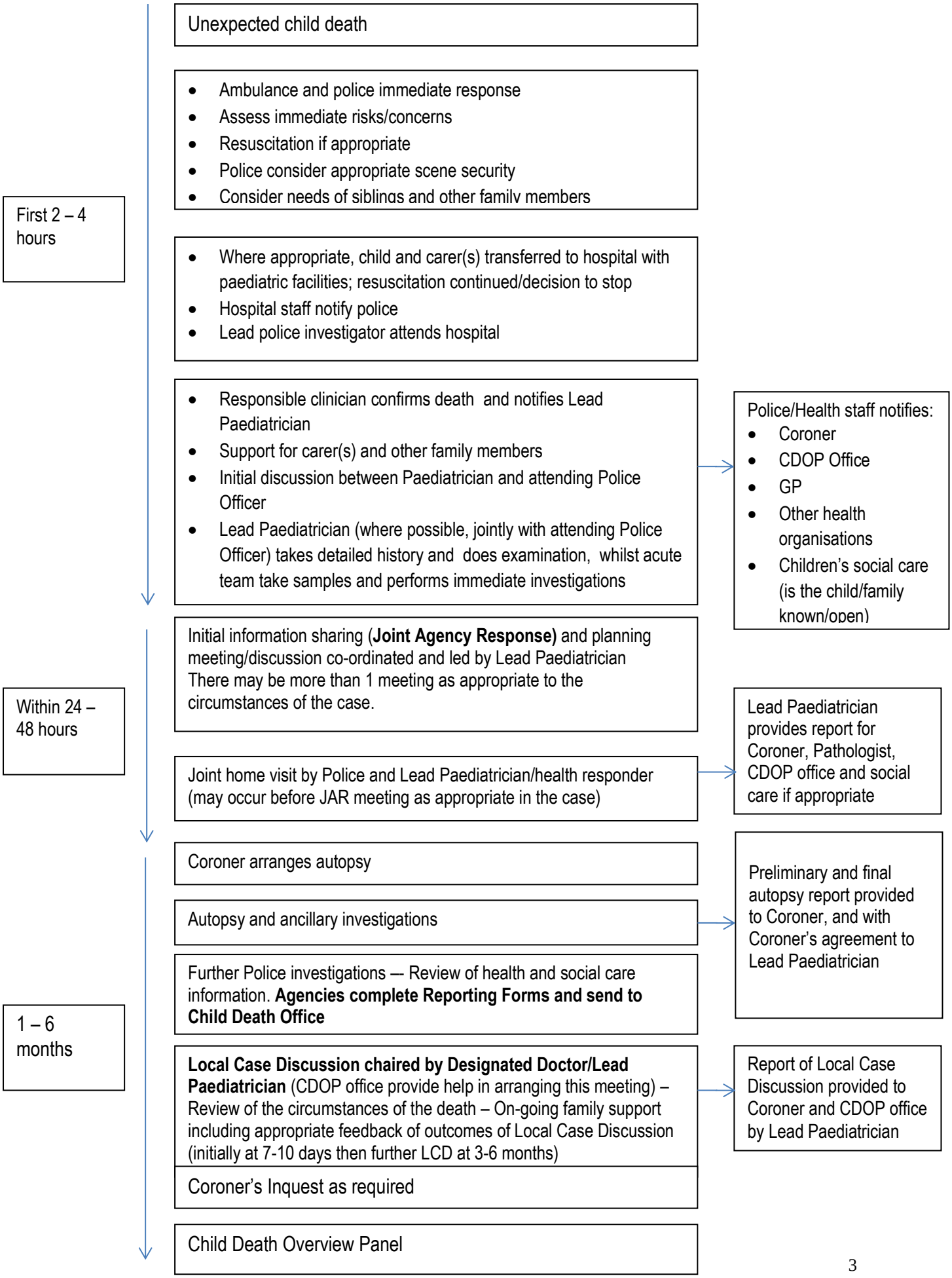
What is an unexpected death?

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. A child with a known life limiting condition may still die suddenly.

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, local authority children's social care and Emergency Duty Service (EDS)) to decide what should happen next and who will do it. (See Flow Chart).
4. Reviews of child deaths should be undertaken for children normally resident in the local area and should be considered for any non-resident child who has died in the local area.

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 Joint Agency response to the unexpected death of a child



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

- Responding quickly to the child's death;
- Following the Joint Agency 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 Notification Form to notify the death and a Reporting Form to provide further information on the death (although a copy of the report sent to the Coroner may be used in lieu of a Reporting Form 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 CDOP office at Bristol University 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 NHS 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 (Joint Agency 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 Joint Agency response meeting to share appropriate information about the deceased child/family and plan next steps. The keyworker should be identified. This will normally be the consultant paediatrician who meets with the family at the time of the child death.

2. This will be called a Joint Agency Response (JAR) meeting. Were abuse is known or suspected to be a factor in the death a referral to MASH will be an action from the JAR meeting if there are surviving siblings of the deceased child who lived in the home.
3. There may be emerging concerns or suspicions within a Joint Agency Response meeting of abuse or neglect in relation to the death. If this is the case then a referral must be an action from the Joint Agency Response meeting, to MASH to consider threshold for a Strategy Discussion for any surviving children who have immediately been impacted upon and are deemed to be at risk. .
4. There may be a number of Joint Agency Response 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 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 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 post mortem 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 MASH/EDS immediately. They should also inform the relevant Safeguarding Partnership (via the

Strategic Manager) in area that the child lived so that they can consider whether the criteria are met for initiating a Serious Case Review.

7. Local Case Discussion

1. Shortly after the **initial** post mortem results become available (approximately 7 – 10 days after death), the Lead Paediatrician/Designated Doctor needs to convene a local multi-agency case discussion (Local Case Discussion), 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 Discussion meeting should be arranged as soon as the final post mortem results become available (approximately 3-6 months in most cases). Parents or Carers of the child are fully informed of this process by the designated keyworker but are not invited to the meetings.
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 Discussion.
3. The professionals attending the LCD 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. The keyworker will be responsible for undertaking appropriate actions arising from this discussion.
4. The Lead Paediatrician/Designated Doctor will complete a Child Death Review Analysis Notification Form 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 Safeguarding Partnerships operate a joint CDOP, which is made up of members from both Local Authority areas (Wiltshire Council and Swindon Borough Council) and a range of different partner 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;
- Conducted for the intention of learning what happened and why, and preventing future child deaths. The information gathered by the panel through local case discussion and wider evidence gathering may help child death review partners to identify modifiable factors that could be altered to prevent future deaths making recommendations to the Local Safeguarding Partnership 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 Local Safeguarding Partnership;
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the Local Safeguarding Partnership -- (via the Strategic Manager) 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. This will go to the Health and Wellbeing Boards in both Local Authorities.
- Make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children
- Contribute to local, regional and national initiatives to improve learning from child death reviews

Flow Chart: Process to be followed for all child deaths