



***Please Note: This policy is currently under review and is still fit for purpose.***

# Rapid Response to Unexpected Child Deaths and Child Deaths Function Standard Operating Procedure

This procedural document supersedes: PAT/T 62 v.1 – Rapid Response to Unexpected Child Deaths and Child Deaths Function Standard Operating Procedure



## Did you print this document yourself?

The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Author/reviewer: (this version)	Gill Genders Lead Nurse for Rapid Response
Date written/revised:	March 2017
Approved by:	Strategic Safeguarding People Board
Date of approval:	26 April 2017
Date issued:	28 April 2017
Next review date:	March 2019 – <b>extended to March 2020</b>
Target audience:	Trust Wide Clinical staff

### Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 2	28 April 2017	<ul style="list-style-type: none"> <li>• Significant changes have been made throughout this document, please read in full.</li> </ul>	G. Genders
Version 1	23 February 2015	<ul style="list-style-type: none"> <li>• This is a new procedural document, please read in full.</li> </ul>	G. Genders

## Contents

Section		Page No.
1	Introduction 1.1 The Child Death Overview Panel (Local Safeguarding Children Board [LSCB] Sub Group) 1.2 The Rapid Response Function (Multi-agency Response to the Unexpected Death of a Child) 1.3 The Multi-Agency Rapid Response Team 1.4 Population Covered	5-7
2	Purpose	7
3	Duties and Responsibilities 3.1 All Trust Staff 3.2 On-Call Managers / Clinical Site Managers 3.3 Heads of Nursing and Quality 3.4 Director of Nursing, Midwifery and Quality 3.5 The Designated Paediatricians for Unexpected Child Deaths 3.6 The Trust Rapid Response Professionals 3.7 Duties of the Lead Nurse Rapid Response 3.8 The Multi-Agency Rapid Response Team	7-11
4	<p><b>Procedure- Please note sections 4.1 and 4.2 describe a similar process as applicable to either ED or the ward environment but there are slight differences, therefore they are written within this policy in this way to enable practitioners within each area to consult the most appropriate area.</b></p> 4.1 Unexpected Deaths within Emergency Department (ED) 4.2 Unexpected Deaths within the Hospital Ward Environment 4.3 Rapid Response to Unexpected Child Deaths Pathway (flowchart) – First 2- 4 Hours 4.4 Hospital led Multi-agency Rapid Response Procedure (Unexpected Child Death). 4.5 Action Required when a Child Dies in Expected Circumstances	11-20
5	Training/Support 5.1 The Trust Rapid Response Team. 5.2 Hospital Clinical Staff Working Predominantly with Children 5.3 All Trust Staff and Community Providers 5.4 Multi- Agency Training	20-21

<b>Section</b>		<b>Page No.</b>
6	Monitoring Compliance with the Procedural Document 6.1 On-going Tracking / Monitoring / Audit Plan	22-23
7	Definitions	23
8	Equality Impact Assessment	23
9	Associated Trust Procedural Documents	24
10	References	24
<b>Appendix 1</b>	The Home Visit	25-26
<b>Appendix 2</b>	Child Death Checklist	27-28
<b>Appendix 3</b>	Equality Impact Assessment Part 1 Initial Screening	29-30

## 1. INTRODUCTION

The vast majority of unexpected child deaths are tragic but natural incidents, however children also die as a result of injury, poisoning, abuse and other avoidable causes. It is every family's right to understand the reasons for the death of their child and recognising this, national policy changes were implemented during 2008, regarding the way agencies respond to and manage child deaths. The aim is to ensure a family centred, systematic yet sensitive service, that is joint agency and immediate in order to investigate all child deaths, to ensure children are safeguarded and to provide support to the families and professionals concerned (Working Together to Safeguard Children HM Gov 2015).

Chapter 5 of Working Together to Safeguard Children (2015) informs the procedures to be followed when there is a child death under the age of 18yrs (excluding still born babies) who normally reside in the Local Safeguarding Children Board area. This means the local Doncaster and Nottinghamshire Safeguarding Children boards are required to ensure that two interrelated processes are in place within the respective geographical areas to ensure the process of multidisciplinary review of all child deaths. The purpose is to better understand how and why children die within the local authority and to use the lessons to take action to prevent deaths and improve the safety of all children within our communities (DCSB and NSCB Safeguarding Procedures; Local Safeguarding Children Board Regulation 6).

### 1.1 The Child Death Overview Panel (Local Safeguarding Children Board [LSCB] Sub Group)

The purpose of the Child Death Overview Panels (CDOP) is to review all child deaths, to identify any modifiable factors that may have contributed to the deaths and identify any support needs for families or staff, any trends, concerns, criminal acts or public health issues. The consideration includes establishing whether the multi-agency response to the death has been appropriate, whether cases require discussion at the Safeguarding Children Board's Serious Case Panels and identifying how best to address any learning from the reviews. Additionally, the Child Death Overview Panel collect, collate and report an agreed national data set of information to the local safeguarding boards and to the government annually in order for learning to be analysed and disseminated nationally.

### 1.2 The Rapid Response Function (Multi-Agency Response to the Unexpected Death of a Child)

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”(Working Together to Safeguard Children, Chapter 5 HM Gov 2015).

The designated paediatrician responsible for unexpected deaths in childhood 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 The Multi-Agency Rapid Response Team

The Rapid Response Team consists of a multi-agency group of professionals that have provided input to the child and family prior to, as a result of or due to the unexpected death of the child. The aims of the Multi-agency Rapid Response team are to establish where possible, a cause or causes of death (in conjunction with the coroner), to identify contributory factors and to provide on-going support to the family.

The multi-agency Rapid Response team are required to;

- Respond quickly to the death of a child.
- Make immediate enquiries and evaluate the reasons for and circumstances of the death, in agreement with the coroner.
- Undertake the types of enquiries or investigations that relate to the current responsibilities of their respective organisations when a child dies unexpectedly, including liaising with those professionals with on-going responsibilities for other family members.
- Collect information in a standard, nationally agreed manner.
- Maintain regular contact with the family or carers and professionals who have responsibilities for other family members, to ensure they remain informed about the child's death and supported in grief.
- Pay regard to equality issues when in contact with families, including gender, ethnicity, disability and sexuality issues relating to the child or relevant family members.
- Identify and respond appropriately to any safeguarding concerns relating to siblings or other children.

### 1.4 Population Covered

***“Deaths of all children under the age of 18 years that normally reside within Doncaster or Bassetlaw”.***

Where a Doncaster or Bassetlaw child dies out of area, it is the role of the Designated Paediatrician for Child Deaths, the Lead Nurse for Rapid Response team or the On-Call Rapid Response Professional, once informed to ensure the process is followed. Dependent upon the location of the death, the team will liaise with the Designated Doctors for Unexpected Child Deaths and relevant professionals within the identified area to negotiate assistance with completion of initial tasks or they may travel, where appropriate to ensure these processes occur.

Where the Rapid Response professionals within the Trust are informed a child from out of area has died within Doncaster or Bassetlaw, they will liaise with the Designated Doctors for Unexpected Child Deaths and relevant professionals within the identified area to negotiate how much assistance with completion of initial tasks can be offered and when the process will be handed over to the relevant professionals within the area that the child lived.

## 2. PURPOSE

There is a statutory requirement that children, who die within the community are taken to Local Accident and Emergency Departments, this initiates the rapid response process where the death is unexpected and relevant information sharing regarding expected deaths.

However, a child under the age of 18 years could also die within any area of the hospital environment or within other external environments, therefore all hospital staff are required to adhere to the agreed procedures and may be called upon to contribute to the processes. This document informs operational practice.

## 3. DUTIES AND RESPONSIBILITIES

### 3.1 All Trust Staff

**NB: Where a death is sudden and unexpected, is unnatural or the cause remains unknown, the Coroner has a statutory responsibility to investigate and where necessary gather evidence and subsequently hold an inquest. Therefore, when dealing with unexpected child deaths within Hospital, all staff should comply with Police instructions.**

All Trust staff must also ensure they adhere to the robust reporting mechanisms outlined within the Doncaster and Nottinghamshire Children Board's safeguarding procedures and this operational policy. The operational duties include;

- Ensuring that families are treated with respect and sensitivity, that a balance is achieved between meeting medical/forensic requirements and evidence preserving and provision of family support.
- Ensuring that the cultural needs of families are recognised, that equality of service is achieved and that all relevant documentation is of a very good standard.
- Ensuring that the Rapid Response team is informed immediately of all deaths of children under the age of 18 years, whether these deaths are expected or unexpected.
- Co-operating with the process and sharing of information as required in a timely manner in order to enable the provision of the Rapid Response service to families within Doncaster and Bassetlaw.

### **3.2 On-Call Managers / Clinical Site Managers**

It is necessary that the Rapid Response team are made aware of all issues relating to all child deaths in order to ensure that the local Safeguarding Children Board Child Death Overview panels receive all relevant information regarding all circumstances prior to and around the time of the child's death. In the event that on call managers /clinical site managers become aware of any issues regarding any child deaths, they should ensure the information is communicated to the Rapid Response team immediately where possible or at 9am the next working day.

### **3.3 Heads of Nursing& Quality**

All Heads of Nursing& Quality should ensure that all staff within individual practice areas are aware of this policy.

### **3.4 Director of Nursing, Midwifery and Quality**

The Director of Nursing Midwifery and Quality will be informed of all child deaths. Where deaths are considered high profile, they will ensure appropriate information sharing within and external to the Trust.

A Contingency plan is available within the Trust Safeguarding Team which will be followed to ensure any gaps in the Hospital Rapid Response service are addressed.

### **3.5 The Designated Paediatricians for Unexpected Child Deaths**

Within the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, (referred to as the Trust), the Designated Paediatricians for Unexpected Child Deaths lead the Rapid Response team and have accountability to oversee all aspects of the Child Death, Rapid Response function. They are supported by a team of Rapid Response Specialist health professionals that assist service delivery.

Once notified of the child's death the Designated Paediatrician for Unexpected Deaths is accountable for ensuring that activities, practice and processes reflect local and national guidelines. This includes the development of medical procedures, the organisation and chairing of relevant meetings to establish the cause of death and the identification of contributory factors, analysis, preparation and presentation of cases to the Child Death Overview Panels and ensuring that information for the coroner is provided in a timely manner in order to inform the coronial investigations.

The Designated Paediatricians for sudden unexpected child deaths attend the Local Safeguarding Children Board Child Death Overview Panels within Nottinghamshire and Doncaster in order to present a summary of all child deaths within the respective areas. They contribute to the multi-agency review of information presented and identify learning within this forum. Where the Designated Paediatrician is unable to attend this forum a nominated deputy (usually the Lead Nurse for Child Death Rapid Response) attends on their behalf and 100% Trust attendance is expected. These professionals have a responsibility to share local and national learning within



the Trust and externally where appropriate, from the child death functions. This should include the provision of regular updates and annual briefings for paediatric colleagues (face to face, within newsletters or via emails) and relevant contribution to external training and initiatives aiming to reduce future deaths.

### 3.6 The Trust Rapid Response Professionals

Whilst all Safeguarding Children Board partner agencies may be required to contribute to the Rapid Response Functions, the Trust, provide a team of Rapid Response to Unexpected Child Death health professionals who, in the absence of the Designated Paediatrician for Child Deaths, maintain all aspects of the Rapid Response to Unexpected Child Deaths Function (Seeking Paediatric Consultant advice as and when relevant). The team provide a 1:6 9am-5pm on-call rota for weekends.

The service is provided seven days per week, from 9am to 5pm, and the on-call team respond immediately to all deaths, whether they are expected or unexpected. The on-call professionals provide the initial aspects of the service, including the completion of a joint home visit (where required for unexpected child deaths) with Police and the organisation of relevant initial meetings and discussions aiming to collect data and support families. The Designated Doctor, Lead Nurse and secretary for the child death functions then co-ordinate and progress the cases and prepare them for discussion at the local Child Death Overview Panels.

**An on-call rota is distributed to switchboards within Doncaster Royal Infirmary and Bassetlaw District General Hospital identifying which professional is on call. In the event, that a staff member needs to inform the team regarding a child death- this should be completed by contacting switchboard, who will then telephone the on-call Rapid Response Team member. In the event that a child dies between the hours 5pm- 9am, Trust staff should ensure the Rapid Response team are informed at 9am the next day.**

Home visits are completed with the Police in order to conduct a scene investigation where appropriate, to gather information and to offer specialised advice within 24 hours of the unexpected death of a child. This procedure is defined within the local safeguarding children board protocols within Doncaster and Bassetlaw. A form B "Home Visit Form" is completed and a copy is sent to the coroner via the Police Senior Investigating Officer at the time of the incident or it is given to Police at the Initial discussion meeting.

**See Appendix 1** for a description of the information established at the home visit.

**Where an unexpected child death does not require a home visit, such as instances where the child has died in a road traffic accident or it is a clear criminal case, the Lead Nurse will make contact with the family within 1 week to offer a home visit- to answer any questions and ensure the family are supported.**

The team work in partnership with other professionals to analyse data and provide regular information both verbally and in report form to the Child Death Overview Panels (CDOP) within Doncaster and Nottinghamshire, and to others in order to facilitate the required individual support and multi-agency case discussion meetings.

***Other duties include;***

- Co-working with Trust staff on complex situations in order to develop competence and confidence in the management of unexpected child deaths.
- The provision of information and data collection in order to contribute to local and national research relating to Child Deaths and participation with other relevant local research projects as required.
- The planning, development and delivery of education and training events for single and multi-agency practitioners and organisations relating to the Child Death Functions as required.
- The collection and collation of evidence and research data to inform the public health agenda and provision of information as required by the local and regional child death overview panels, ensuring efforts are targeted demographically at the areas with highest risks of child deaths across Doncaster and Bassetlaw.

### **3.7 DUTIES of the Lead Nurse Rapid Response**

The Lead Nurse for Rapid Response works collaboratively with the Designated Paediatricians for Unexpected Child Deaths and relevant others in order to provide professional strategic leadership and expertise in the planning, development and provision of preventative strategies, multi-agency policies and practice aimed at reducing child deaths across Doncaster and Bassetlaw.

It is the role of Lead Nurse Rapid Response to ensure that there are robust internal policies and guidance in place regarding the Child Death Functions and to act as a focal point for the dissemination of information in relation to policy, procedures, practice and training.

***Other duties;***

- The promotion of effective working relationships between health trusts and other Statutory/non statutory partners relating to Safeguarding Children and the Child Death functions.
- To lead the development of trust operational procedures in line with Local Safeguarding Children Board Procedures, specifically relating to the multi-agency coordinated response to the unexpected death of a child up to the age of eighteen years.

- To work with the Trust Child Death Administrator and Designated Doctors for Unexpected Child Deaths to ensure that processes are in place that enable timely management and completion of all relevant processes relating to the child death caseload.
- To assist the Designated Doctors with all aspects of the child death functions and preparation of cases, including extensive information gathering in order to progress cases to CDOP.
- To ensure representation of the Trust to multi-agency Child Death meetings across Doncaster and Nottinghamshire. This includes meeting with coroners, 3 monthly Sudden Unexpected Death in Infancy (SUDIC) Meetings and local and regional Child Death Overview Panels (CDOP) panels within both Doncaster and Bassetlaw.
- To ensure that learning and best practice identified from internal practice or peers within other local Child Death teams and child death networks is incorporated into procedures and practice and all aspects of child death work.
- To work in partnership with other Trusts, the local authority, voluntary agencies and families to promote the protection and wellbeing of children and all aspects of the child death functions.

### **3.8 The Multi-Agency Rapid Response Team**

The multi-agency rapid response team involves all staff that have been involved with a child and / or the family prior to, or as a result of the death. It is the duty of the Multi-Agency Rapid Response team to ensure that families are supported and that information relating to the circumstances surrounding the child death is collected and analysed in a timely manner. The minutes of multi-agency child death meetings are copied to the coroners within both Doncaster and Bassetlaw in order to assist in the Coroner's investigation or inquest as appropriate. Within Doncaster, minutes of child death meetings are copied to the chair of the DSCB Case Review Group. Minutes will be produced and distributed within 2 weeks.

It is the responsibility of the Multi-agency Rapid Response Team to contribute fully to the process, to consider all circumstances of the death and to ensure that all relevant learning is included before the case is presented to CDOP.

## **4. PROCEDURE**

### **4.1 Unexpected Deaths within Emergency Department (ED)**

Children who die unexpectedly within the community should be presented to the local Emergency Department (ED), according to the location of their home address or the scene of death. They are usually conveyed to hospital by ambulance staff and accompanied by Police. This arrangement applies for all children under 18 years of age. The exception normally relates to situations where it is clear to paramedics and police in attendance, that resuscitation is not

appropriate and a forensic examination is required. Additionally, there may be situations where children that have died unexpectedly are conveyed to hospital by family and/or friends (DSCB and NSCB Safeguarding Procedures).

***Upon obtaining the information that a child has died unexpectedly and is to be conveyed to ED;***

- ED staff must inform the Emergency Department Consultant on-call and Consultant Paediatrician on-call if the child is under 16 years.
- A member of hospital staff must be allocated to remain with the parents or carers and support them throughout the process. When in attendance, the family may stay with their child or within the quiet room according to their wishes. Staff must refer to the child by its name at all times.
- Staff must check the child's address and post-code, in order to inform the person on-call for the Rapid Response to Unexpected Child Deaths. This requirement enables the prompt sharing of information and enablement of the process when a child lives out of area.
- Where English is not the preferred language of the parents, carers or family, interpreter services should be provided. This requirement must be communicated to members of the Rapid Response team.

**On-Call Paediatrician /Emergency Department Consultant On-Call**

As soon as possible on arrival at the hospital, the child under 16 years of age must be examined by the Consultant Paediatrician on-call. For children over 16 years of age, this may be the Consultant in Emergency Medicine or other relevant adult Consultant. The Paediatrician/Consultant must take a detailed history of events leading up to and following the discovery of the child's collapse, and follow the procedures outlined within the specific documents for managing Sudden Unexpected Deaths within ED (Sudden Unexpected Deaths in Children up to the age of 18 years). The document will be situated within the child death boxes within the ED departments at Doncaster and Bassetlaw. NB there are some specific differences regarding the management of child deaths within Doncaster and Bassetlaw and clinicians should ensure the relevant guidance is followed.

The Sudden Unexpected Deaths in Children up to the age of 18 years medical document outlines the requirements of the initial medical assessment, management and procedures that must be followed in the event of a sudden unexpected death of a child. They incorporate guidelines regarding the management of;

- Resuscitation, hospital care and confirmation of death,
- Examination post death and post death investigations
- Family profile and history
- Medical History
- Recent Events
- Nursing and Medical Checklists.

Ensure that all the original copies are filed in the emergency department record and that copies are made available for the Rapid Response Team. The Rapid Response on-call person is responsible to share the document with the relevant coroner in a timely manner. This process will help to establish the cause of death when appropriate, and help to identify if there are any suspicious circumstances.

Any cause for suspicion must be reported immediately to the on-call Detective Police Inspector. In the first instance, this must be discussed with the Police Senior Investigating Officer allocated to the case. Where safeguarding concerns are identified actions must be taken in line with Doncaster or Nottinghamshire Safeguarding Children procedures and staff should ensure that actions are taken to protect any siblings within the family, if appropriate.

***When the death is confirmed;***

- The attending paediatrician or physician must inform the parents, having first reviewed all available information.
- Staff must contact Children's Social Care within the appropriate geographical area to inform them of the child's death and to establish whether the child was subject to a child protection plan. The outcome of this discussion must be clearly documented within the child's record and shared with the person on-call for the Rapid Response to Unexpected child death service. Any safeguarding concerns must be acted upon in accordance with Nottinghamshire or Doncaster Safeguarding Children Board procedures as relevant.
- Medical and Nursing staff must ensure the child death information sharing Checklist is completed (**See Appendix 2**).
- Medical and Nursing staff must ensure that parents and families understand the role and process of the Multi-Agency Rapid Response to Unexpected Child Death Team and written information must be given to the parents/carers to support the discussion. Unless sharing of information with family members would jeopardise a police or criminal investigation, parents and carers must always be informed and kept- up to date about any new findings.
- Prior to transferring a child to the mortuary, the child can be redressed. Any secretions to a child's face should not be washed (the pathologist needs to assess whether any fluids to the face are significant). ETT, Cannulas and any tubes- for Bassetlaw should be left in situ. For Doncaster these may be cut but remain in situ. The pathologist requires this in order to check their placement.
- When nappies, clothing etc. are removed, they must be stored in individual labelled hospital or evidence bags and stay initially with the child. A discussion with Police is necessary to ascertain whether they will take charge of the belongings or whether they accompany the child when transferred to the mortuary.
- When a child dies in **Doncaster** and is transferred to Sheffield for post mortem, an empty memory box should be provided which will eventually contain hand and footprints,

photographs and a lock of hair. Doncaster staff should explain to parents/ carers that the memory box will go with the child to the mortuary and then to Sheffield where the process will be completed. However, it is necessary to gain consent from the parents and the completed consent form will go with the child to Sheffield. ED staff should then ensure the Mortuary attendant is aware the memory box and consent form will escort the child to Sheffield for post mortem. A copy of the consent form should be filed within the patient's health record.

- **In Bassetlaw only-** Staff should obtain consent and provide a memory box. Families should be given a copy of the completed consent form and a copy filed within the child's health record. **NB In suspicious circumstances do not remove keepsakes for the family.**
- Patient identification labels must be attached to both the wrist and ankle of the child. All deceased children must be sent to the mortuary wearing their original inpatient identity band. This must not be removed or replaced. An additional identification band will be added bearing the full name and address of the deceased, age and date of admission (see Patient Identification Policy PAT/PS 7).

### ***Care of the Family***

- Ask the parents if they would like anyone to be informed of the death e.g. partner, grandparents, religious leader.
- Ask parents/carers if they would like you to contact the hospital chaplain or their own religious leaders in order to provide spiritual care. Where appropriate, ask if there are any religious rites that should be adhered to following the death of their child. **NB: The Hospital Chaplain is on call 24 hours per day and can be contacted via switchboard.**
- Give the parents a copy of the Trusts' Bereavement Leaflet (WPR28831). This leaflet provides information for parents regarding what happens after their child has died. Ensure that it is documented within the child's health record that explanatory leaflets have been given to the parents/carers.

Encourage parents and carers to see and hold the child (but never leave them unsupervised). This is to ensure a balance between sensitivity towards the family and the need for the Police and Coroners to investigate all unexpected deaths (Doncaster and Nottinghamshire Safeguarding Children Procedures; Baroness H. Kennedy 2016; Association of Chief Police Officers 2014).

### ***Before the family leave Hospital***

- Ask the parents/carers where they are going and document in the child's record, their address, and contact telephone number and how they will get there safely. Make sure they are not alone wherever possible and offer hospital transport if required.

- Ensure the parents/ family know they can visit their child to pay last respects at the Hospital Mortuary prior to transfer for a post mortem and this can be arranged by either telephoning the department or ringing the mortuary (Contact details are included within the Trusts' bereavement Leaflet -WPR28831).
- Ensure parents are aware of the contact numbers within the Lullaby Trust Leaflet, of local Child Death /Rapid Response professionals whom they can contact for advice/ or with questions after they have gone home.

#### 4.2 Unexpected Deaths within the Hospital Ward Environment

**NB- For children aged 16 & 17 years within the adult ward- the process below should be adapted to the adult ward environment.**

***The Paediatrician's Role (or Registrar in the absence of the Consultant) when a death is unexpected.***

The Paediatric Consultant assesses and certifies the child/young person's death. They will inform the parents of the child's death and ensure that a detailed history of events leading up to and following the discovery of the child's collapse is recorded within the medical child death document.

The Senior Paediatrician (Consultant or Registrar) will explain to the family, that the case will be referred to the Coroner. He/she should also explain that the Coroner's role is to determine the cause of death and whether it is likely that a post-mortem examination will take place. NB: If a child lives out of area, it should still be referred to the Coroner covering the geographical area of the child death.

1. The Paediatric Consultant will complete the referral of the child to the Coroner. Additionally, the family should be told the likely venue and timing.

*In extreme cases where the Consultant is unable to attend the ward, the Registrar may be required to complete the above.*

2. The Paediatric Consultant will ensure that all relevant documentation is completed within the child's health record.
3. Where additional investigations are required, the on-call paediatrician should liaise with x-ray and Ophthalmologist on call or others as appropriate.
4. Medical Staff should inform Police immediately (applies 24 hours per day) of all unexpected child deaths. It is the role of the Police to assist the coroner with the investigation of circumstances surrounding all unexpected child deaths. Document actions taken within the child's records.

5. The Family will be introduced to an identified staff member, who will be dedicated to their care until they leave the hospital.

6. Medical staff should complete the relevant parts of the Child Death Checklist (WPR27963)

***Immediately following the child death, the following actions should be completed by ward staff:***

1. Inform the Children and Family Care Group matron/nurse manager/clinical site manager.

2. Inform Children's Social Care immediately (24 hours per day) that there has been an unexpected child death.

This phone call should include:-

- A check whether the child was subject to a Child Protection Plan and the outcome of this discussion with social care and any safeguarding concerns or actions taken must be clearly documented within the child's record and shared with the person on-call for the Rapid Response to child death service.

- A written multi-agency referral form should be forwarded to Children's Social Care (Bassetlaw-MASH or Doncaster Referral and Response Team according to the child's address).

3. Ward Staff should inform the Trust Rapid Response person on-call via switchboard. In the event that a child dies between the hours 5pm- 9am, Trust staff should ensure the Rapid Response team are informed at 9am the next day.

4. Complete the relevant aspects of the Child Death Checklist (WPR27963).

***Care of the Family***

Medical and nursing staff should work together to sensitively ensure that parents or carers receive high quality care, support and information during this this very traumatic time.

Where English is not the first language every attempt should be made to provide a translation/interpreting service including out of hours provision, for example through the "Big Word" language line.

Parents/carers should be allowed to stay with their child (with supervision) or remain in a quiet room, according to their wishes and hospital staff should:

- Briefly explain the role of the multi-agency Rapid Response Procedures for Unexpected Child Deaths and give parents the Lullaby Trust leaflet. Explain to parents sensitively that the child death procedures are routine for all child deaths and aim to find out what has caused their child to die. Inform the parents, that the Police may wish to complete a home visit with or without a



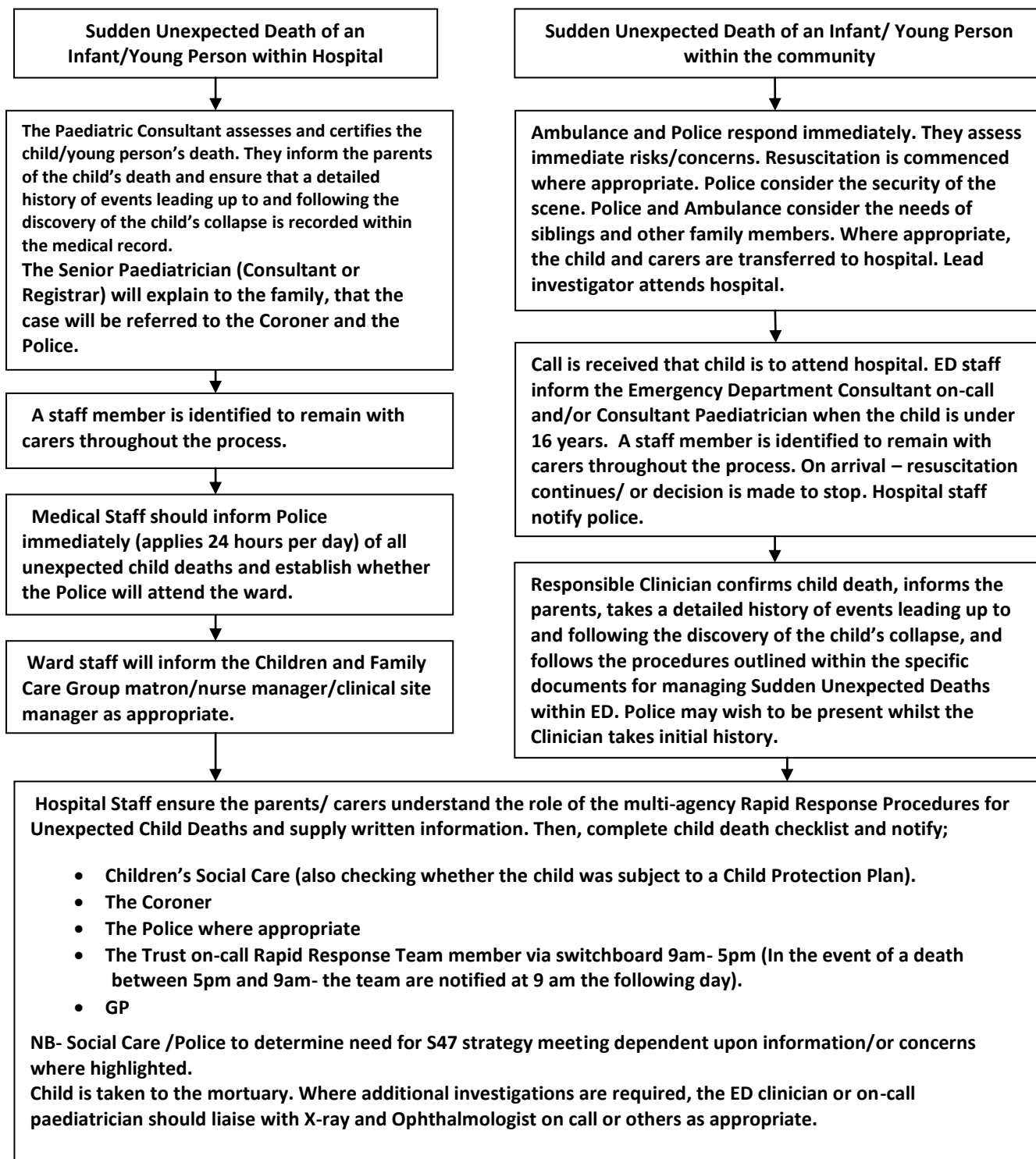
Rapid Response professional, additionally that they may choose to attend the ward. This is routine practice and is not an indication that the parents are suspected of being responsible for the death. Additionally, inform parents that they will be informed and kept- up to date about any new findings.

- Ask the parents if they would like anyone to be informed of the death e.g. partner, grandparents, religious leader.
- Ask parents/carers if they would like you to contact the hospital chaplain or their own religious leaders in order to provide spiritual care. Where appropriate, ask if there are any religious rites that should be adhered to following the death of their child. NB: The Hospital Chaplain is on call 24 hours per day and can be contacted via switchboard.
- **Give the parents a copy of the Trusts' Bereavement Leaflet (WPR28831).** This leaflet provides information for parents regarding what happens after their child has died. Ensure that it is documented within the child's health record that explanatory leaflets have been given to the parents/carers.
- Encourage parents and carers to see and hold the child (but never leave them unsupervised).

#### ***Before the family leave Hospital***

- Ask the parents/carers where they are going and document in the child's record, their address, contact telephone number and how they will get there safely. Make sure they are not alone wherever possible and offer hospital transport if required.
- Ensure the parents/ family know they can visit their child to pay last respects at the Hospital Mortuary prior to transfer for a post mortem and this can be arranged by either telephoning the ward or ringing the mortuary (Contact details are included within the Trusts' bereavement Leaflet -WPR28831).
- Ensure parents are aware of the contact numbers within the Lullaby Trust Leaflet, of local Child Death /Rapid Response professionals whom they can contact for advice/ or with questions after they have gone home.

### 4.3 Rapid Response to Unexpected Child Death Pathway First 2-4 Hours



#### 4.4 Hospital led Multi-agency Rapid Response Procedure (Unexpected Child Death).

Rapid Response person on-call receives notification of unexpected child death.

*Initial actions within 24 hours;*

##### Datix Reporting

When informed of a child dying unexpectedly within the hospital environment, whilst receiving care as an inpatient or outpatient and where there are incidents relating to the hospital attendance and care provided, the on-call Rapid Response person will ask the person providing information to ensure the unexpected death or related incident is reported as an adverse incident via the Datix Reporting system within the Trust.

- Where appropriate they will make immediate contact with ED or appropriate area for further details and the Police to organise the home visit. Where it is inappropriate to conduct a home visit- the decision should be agreed with the Designated Paediatrician for Child Deaths where possible and the Police.
- Complete Child Death Information Sharing Proforma to notify local NHS managers and local CDOP of the initial information.
- Share information as appropriate, written or verbally where required (for instance where safeguarding concerns are present).
- Establish contact details of those multi-agency professionals known to the child and family prior to or as a result of the death.
- Commence national dataset Form A- notification of Child Death and form A1, then forward to the
- CDOP administrators once complete (within 24 hours).

A Joint visit with Police/ Designated Paediatrician or Rapid Response Nurse for Unexpected Child Deaths to the family is completed within 12 hours wherever possible in line with good practice (P. Sidebotham and P. Flemming 2007). The Rapid Response person will ensure a follow- up contact number is provided to parents unless inappropriate (i.e. due to criminal proceedings).

The Rapid Response Person completes Form B Local Home Visit document and ensures that a copy is sent to the coroner via the Police Senior Investigating Officer. Where safeguarding concerns are present, information sharing and actions will occur immediately in line with NSCB or DSCB procedures.

An Initial discussion meeting is organised by the Rapid Response team, to occur within 3 working days, to bring together the Multi-agency Rapid Response Team. The purpose of this meeting is to discuss initial post mortem results, to share all relevant multi-agency information relating to the family and the circumstances of the death, to inform investigations and to ensure plans are in place to support families and professionals involved. The group will consider whether there are any safeguarding concerns and if so, ensure these are addressed in line with DSCB and NSCB procedures. Additionally, the group will consider whether information known should be referred to the local Serious Case Panels for discussion. Minutes of this meeting will be produced and distributed by the Hospital Rapid Response team within 2 weeks to the coroner and relevant others. Timescales for actions will be detailed within the meeting minutes and the chair of the meeting will hold responsibility for ensuring timescales are met and actions monitored.

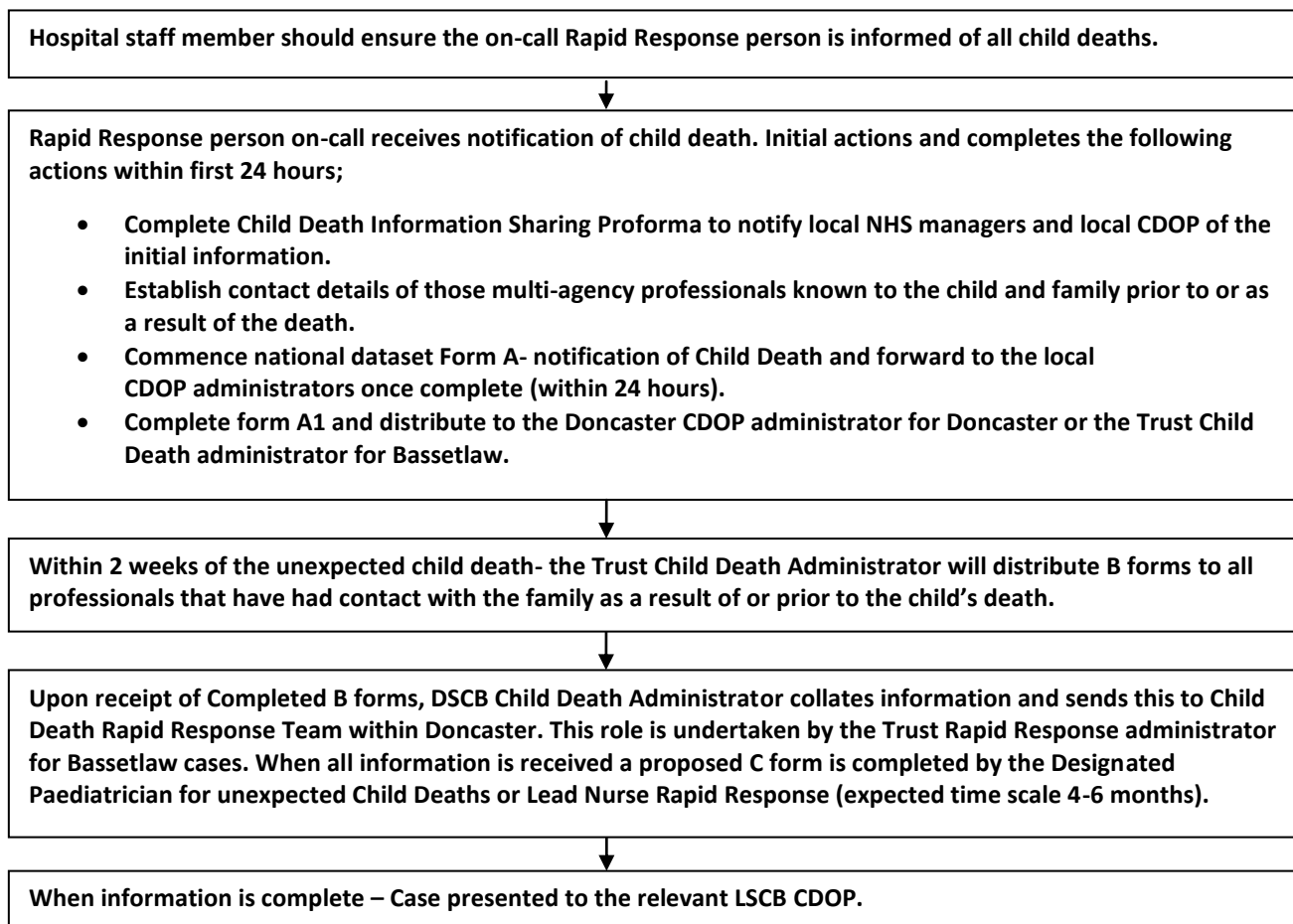
Within 2 weeks of the unexpected child death- B forms will be distributed to all professionals that have had contact with the family as a result of or prior to the child's death. The Trust Child Death administrator will be responsible for management of responses and chasing up non- response.

At 12 weeks post death, the Trust Child Death Administrator will request post mortem reports from the Coroner's offices in Doncaster or Nottinghamshire.

Upon receipt of Completed B forms, DSCB Child Death Administrator collates information and sends this to Child Death Rapid Response Team within Doncaster. This role is undertaken by the Trust Rapid Response administrator for Bassetlaw cases. When post mortem reports are received (expected time scale 3- 6 months) - Final Findings meeting to be arranged. Meeting to ensure all circumstances of the case are reviewed and arrangements made to ensure family support. Minutes to be distributed within 2 weeks.

The proposed C form is produced and case sent for discussion at the Child Death Overview Panel (expected time scale 6-12 months). Cases presented and discussed at CDOP post inquest.

#### 4.5 Action Required when a Child Dies in Expected Circumstances



## 5. TRAINING/ SUPPORT

### 5.1 The Trust Rapid Response Team

- All Rapid Response Team members will access Safeguarding Children Training at a minimum level 3 and maintain competencies according to the “Safeguarding children and young people: roles and competences for health care staff, Intercollegiate Document ” RCPH and CH Third edition: March 2014.
- All Rapid Response Team members will access relevant Child Death Process Training within 6 months of appointment and will maintain their knowledge and skills through attendance to relevant training and network events.
- Training needs for Rapid Response Team members will be discussed and recorded as part of the annual Performance and Development Appraisal process. Action plans will be developed where required to meet any identified unmet training needs.

- All Rapid Response Team members will access relevant peer support and supervision on a quarterly basis.
- Psychological support will be provided by the Trust as required.

## **5.2 Hospital Clinical Staff Working Predominantly with Children**

In line with the “Safeguarding children and young people: roles and competences for health care staff, Intercollegiate Document” RCPH and CH Third edition: March 2014, staff groups that work predominantly with children will acquire level 3 safeguarding Children competencies. This includes midwives, children’s nurses, therapists and ED clinical staff. In order to ensure, these staff groups are aware of the Child Death process, safeguarding training delivered at level 3 within the Trust will reference the Child Death process, procedures and expectations of staff.

Learning from individual cases will be disseminated within the Trust as relevant. For example; within Paediatrician’s Peer Group Supervision sessions/ newsletters/ individual feedback.

## **5.3 All Trust Staff and Community Providers**

All Trust staff should be made aware of this operational policy in order to ensure they are equipped to deal with individual cases on an ad hoc basis.

The Lead Nurse for Rapid Response will produce an annual newsletter, commencing April 2015, which will be published on the Trust Safeguarding Website and shared with Doncaster and Bassetlaw Community providers in order to ensure that learning from the Child Deaths functions is shared locally.

## **5.4 Multi-Agency Training**

On an annual basis, the Lead Nurse for Rapid Response will contact the multi-agency Training Managers within Doncaster and Bassetlaw in order to offer up to 6 Multi- Agency Child Death Functions sessions per year.

## 6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

### 6.1 On-Going Tracking/ Monitoring / Audit Plan

<b>What is being Monitored</b>	<b>Who will carry out the Monitoring</b>	<b>How often</b>	<b>How Reviewed/ Where Reported to</b>
Rapid response to Unexpected Child Deaths occurs within 24 hours	Lead Nurse for Rapid Response and Trust Child Death Administrator	On an on-going basis. All cases will be tracked within an internal tracking document. Tracking will include adherence to policy requirements and timescales.	Quarterly Safeguarding Report to include report of Rapid Response activities, achievements and exceptions, including actions taken where appropriate to mitigate risk.
Rapid Response to Unexpected Child Deaths process meets the expected timescales as identified within this policy.	Lead Nurse for Rapid Response and Trust Child Death Administrator	On an on-going basis. As above.	
Designated Doctor attendance to the Doncaster and Bassetlaw CDOPs. Child Death Overview Panel.	Lead Nurse for Rapid Response and Trust Child Death Administrator	Quarterly	Minutes of LSCB CDOP will be utilised to confirm attendance and/ or nominated Deputy attendance where appropriate to NSCB and DSCB CDOPs. Same to be reported within the Trust Safeguarding Quarterly Report. Exceptions and actions taken where appropriate to mitigate any related risks will be reported within the Trust's Rapid Response Issues log and the Trust Safeguarding Quarterly Report.
Trust Representation to the Doncaster and Bassetlaw CDOPs. Child Death Overview Panel	Lead Nurse for Rapid Response	Quarterly	As above.
Rapid Response Rotas - Cover will be provided 9am-5pm 7 days per week and will cover both	Lead Nurse for Rapid Response and Trust Child Death Administrator	On-going.	Where, for unforeseen reasons, the Trust is unable to provide Rapid Response rota cover- this will be escalated

Doncaster and Bassetlaw geographical areas in line with the NSCB and DSCB procedures.			within the Trust to the Head of Safeguarding and /or Deputy Director of Nursing and Quality immediately. This, and actions taken to mitigate risks will be recorded within the Rapid Response issues log and reported quarterly within the Trust Safeguarding Quarterly Report.
Contribution to the Doncaster and Nottinghamshire Annual Reports, led by the CDOP Chairs.	Designated Paediatricians for Unexpected Child Deaths within Doncaster and Bassetlaw.	Annually	Annual reports to be provided to the relevant

## 7. DEFINITIONS

**ED**- Emergency Department

**CDOP** -Child Death Overview Panel

**DSCB** - Doncaster Safeguarding Children Board

**EIA** - Equality Impact Assessment

**LSCB** - Local Safeguarding Children Board

**NSCB** - Nottinghamshire Safeguarding Children Board

**DSCB**- Doncaster Safeguarding Children Board

**SUDIC** -Sudden Unexpected Death in Childhood

**SCR** - Serious Case Review

**The Trust** - Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

## 8. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. See Appendix 3.

## 9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Staff should also consider the following policies and documents when applying this operational procedure;

- Death of a Patient: Operational Policy for staff to follow in the event of a patient death - PAT/T 60
- Safeguarding Children Policy PAT/PS 10

## 10. REFERENCES

- Association of Chief Police Officers (2014) "A guide to investigating child deaths".
- Doncaster Safeguarding Children Board Procedures (available online via the Trust Intranet policy page).  
<http://www.doncastersafeguardingchildren.co.uk/>
- Information Sharing: Guidance for Practitioners and Managers (HM Government) DBH Website Department for Education (2015) Information Sharing: Advice for practitioners providing safeguarding services. DfE, London.
- Nottinghamshire Safeguarding Children Procedures (available online via the Trust Intranet policy page).  
<http://www.nottinghamshire.gov.uk/caring/protecting-and-safeguarding/nscb/>
- Royal College of Pathologists and The Royal College of Paediatricians and Child Health (2016) Sudden Unexpected death in infancy and childhood. Chair; Baroness H Kennedy.
- " RCPH and CH Third edition: March 2014. "Safeguarding children and young people: roles and competences for health care staff, Intercollegiate Document. Royal College of Paediatricians and Child Health.
- Working Together to Safeguard Children (2015) HM Government



## APPENDIX 1 – THE HOME VISIT

### Information Gathering at the Home Visit

The HMR 7 Home Visit Form Requires the Rapid Response Person to establish information as below;

- Child's Unit Number, family and identification details, child's place of birth and place of death.

**The Interview of Parents establishes below information;**

- Paediatrician details
- Police Officer details
- Parents details
- GP's details
- Midwife details
- Health visitor's details
- Name of the main carer
- Details of other carers/members of the household - any concerns e.g. child-minder, grandparents
- Details of siblings (in household and others) including name and date of birth and health problems.
- A Completed genogram
- Detailed medical history of mother includes past medical history and obstetric history. Social and Family History is taken to include a detailed account of social structure of the family and household. Employment/income and any relevant detailed information regarding whether there is any family smoking/alcohol intake and other drug use.
- Any family history of illness including any infant/childhood deaths.
- Information regarding fathers or partners health.
- Establish whether any medication in the household and who has had contact with baby since death:
- Detailed medical and developmental history of baby who has died
- Babies gestation/birth weight, any perinatal/neonatal problems and type of feeding. Details regarding sterilisation and making of feeds.
- Growth/development and any concerns.
- Child's past medical history and any contact with infections
- Child's general health, contact with health professionals, allergies and recent medication
- Details regarding any pets in the home
- Details of immunisations
- A detailed narrative account of baby's feeding/sleeping/activity and health over the two week period to death
- A detailed (hour by hour) narrative account of events within the 24-48 hours prior to the infant being found dead, including the final sleep.

- An account of when the baby was found, including who called for medical emergency services and how long they took to arrive:

### **Scene of Death**

The Rapid Response Person on-call then considers the room where the baby was found, including;

- The temperature in the room, the type of heating in the house and a thermostat temperature (check).
- Details whether the windows and/or doors open?
- The Rapid Response Person on-call then completes a sketch of the room noting windows/door, position of sleeping surface/radiators/other heaters.
- Police SOCO (Scene of Crimes Officer) or CSI (Scene of Crimes Investigator) photograph the home.

### **Recording on the Home Visit Form details;**

- Hospital staff involved
- Details of ambulance staff:
- Information regarding the declaration of death
- Details of the scene of death visit
- Whether clothing/items are seized and why.
- Action by SOCO/ SIO (Scene if Crime Investigator or Scene Investigator Officer).
- A written account of a full check the whole house including bedrooms, fridge, kitchen, bathroom, noting any signs of neglect, poor hygiene etc.
- Details of a Social Service check, relating to all members of the family.


### **Outcome of Police Checks**

- CAIU ( Child Abuse Investigation Unit)check:
- Domestic Violence Unit check:
- Police Intelligence check:
- PNC(Police National Computer) check:
- CATS(Case Administration Tracking System) check:

### **The Rapid Response Person on-call then considers if there is;**

- Evidence of over-wrapping or over-heating
- Any restriction to ventilation or breathing
- Any risk of smothering
- Any potential hazards
- Any evidence of neglectful care

## APPENDIX 2 – CHILD DEATH CHECKLIST

 <b>Doncaster and Bassetlaw Teaching Hospitals</b> NHS Foundation Trust  <b>SUDDEN UNEXPECTED DEATH OF A CHILD (UNDER 18 YEARS)</b>	<p style="text-align: right;">AFFIX LABEL HERE IF AVAILABLE</p> NHS Number: _____ District Number: _____ Surname: _____ Forename(s): _____ Address: _____ _____ D.o.B.: _____
	Date of death: _____ Time of death: _____ Place of death: _____ Ethnic origin of family: _____ 1st language of family: _____ Interpreter Used: <input type="checkbox"/> Yes <input type="checkbox"/> No (If 'no' comment over the page) <input type="checkbox"/> N/A <input type="checkbox"/> <b>Parents/Guardians (tick box if present)</b> <input type="checkbox"/> Name: _____ Relationship to child: _____ Tel: _____ <input type="checkbox"/> Name: _____ Relationship to child: _____ Tel: _____ <input type="checkbox"/> Name: _____ Relationship to child: _____ Tel: _____ Names of siblings and supporting family members present: _____ _____ <input type="checkbox"/> Senior Paediatrician (Cons/Reg) or other relevant consultant assesses and certifies the child/young persons death. Name of doctor (Print): _____ Designation: _____ <input type="checkbox"/> Religious rites discussed and offered if circumstances appropriate Religion: _____ <input type="checkbox"/> Parent(s)/guardian(s) given child death review information and bereavement leaflet <input type="checkbox"/> Parents/Guardians informed of the role of the Police to assist the Coroner? <input type="checkbox"/> Memory box consent obtained <b>The following must be informed:</b> <input type="checkbox"/> Coroner Date/Time: _____ <input type="checkbox"/> Police Date/Time: _____ <input type="checkbox"/> Social Care (Referral and Response) and establish if the child is subject to a Child Protection Plan Date/Time: _____ <input type="checkbox"/> Complete Multi Agency Referral Date/Time: _____ <input type="checkbox"/> Rapid Response person on call 9am to 5pm (out of hours inform them at 9am the next day) Date/Time: _____ <input type="checkbox"/> Clinical Site Manager/Duty Matron Date/Time: _____ <input type="checkbox"/> GP Date/Time: _____ <input type="checkbox"/> Paediatric Liaison 9am to 5pm Date/Time: _____ <input type="checkbox"/> Named consultant/paediatrician Date/Time: _____ <b>Consider Informing the following people as appropriate:</b> <input type="checkbox"/> Children's Services Head of Nursing/Matron (if death occurs whilst child is an Inpatient) <input type="checkbox"/> DRI Paediatric Nurse bleep holder (if death occurs whilst child is an inpatient) <input type="checkbox"/> Midwife if child aged under 28 days <input type="checkbox"/> Neonatal Nurse if appropriate <input type="checkbox"/> Safeguarding Children/Child Protection Team <input type="checkbox"/> Datix Incident form completed, if appropriate If 'Yes', Datix code No: _____ Designation & Name: _____ Signature: _____ Date & Time: _____



WPR27963  
Jan 2017  
WHITE

Property given to Police?  Yes  No

Property form completed?  Yes  No

Specify any tubes/cannulae

- Doncaster tubes may be cut down but not removed
- Bassetlaw tubes must remain in situ

Date and Time	Communication/Comments/Evaluation	Signature Print name Designation

Proof February 24th 2017

Additional people spoken to:  
\_\_\_\_\_  
\_\_\_\_\_

Incident number:  
\_\_\_\_\_  
\_\_\_\_\_

**APPENDIX 3 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING**

Service/Function/Policy/ Project/Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
PAT/T 62 v.2	Safeguarding Team	Gill Genders - Lead Nurse for Rapid Response	Revised policy	03.03.2017
<b>1) Who is responsible for this policy?</b> Lead Nurse for Rapid Response				
<b>2) Describe the purpose of the service / function / policy / project/ strategy?</b> Who is it intended to benefit? What are the intended outcomes? This policy is intended to provide guidance for managers and staff in relation to applying the local safeguarding children board and national guidance procedures following the death of a child within the Trust. The policy covers all staff within the Trust. The objective of the policy is to provide guidance for staff to follow in the event of an expected or unexpected child death and includes details of the procedure to follow.				
<b>3) Are there any associated objectives?</b> Local Safeguarding Board Procedures, National Statutory Guidance and service contract.				
<b>4) What factors contribute or detract from achieving intended outcomes?</b> – Potential for discrimination relates to non-adherence to the policy				
<b>5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?</b> Details: [see Equality Impact Assessment Guidance] - Potential for discrimination relates to non- adherence to the policy <ul style="list-style-type: none"> <li>If yes, please describe current or planned activities to address the impact [e.g. Monitoring, consultation] – On-going monitoring of service delivery, quality of practice and documentation.</li> </ul>				
<b>6) Is there any scope for new measures which would promote equality?</b> [any actions to be taken] No				
<b>7) Are any of the following groups adversely affected by the policy?</b>				
<b>Protected Characteristics</b>	<b>Affected?</b>	<b>Impact</b>		
a) Age	No	No		
b) Disability	No	No		
c) Gender	No	No		
d) Gender Reassignment	No	No		
e) Marriage/Civil Partnership	No	No		
f) Maternity/Pregnancy	No	No		
g) Race	No	No		
h) Religion/Belief	No	No		
i) Sexual Orientation	No	No		

<b>8) Provide the Equality Rating of the service / function /policy / project / strategy – tick outcome box</b>			
<b>Outcome 1</b> ✓	<b>Outcome 2</b>	<b>Outcome 3</b>	<b>Outcome 4</b>
<i>*If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a Detailed Equality Analysis form in Appendix 4</i>			
<b>Date for next review:</b> 30.03.2019			
<b>Checked by:</b> Gill Genders		<b>Date:</b> 31.03.2017	