Unexpected Deaths in Childhood, Joint Agency Response

Guideline

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1.0 INTRODUCTION and KEY POINTS:

1.1 A Joint Agency Response (JAR) should be triggered if a child's death is considered to be 'unexpected'. That is, it:

a. Is or could be due to external causes

b. Is sudden and there is no immediately apparent cause (incl. SUDI/C)

c. Occurs in custody, or where the child was detained under the Mental Health Act where the initial circumstances are unclear or raise any suspicions that the death may not have been natural

d. In the case of a stillbirth where no healthcare profession was in attendance.

1.2 The aims of the response are to:

a. establish, as far as is possible, the cause or causes of the infant's death

b. identify any potential contributory or modifiable factors

c. provide ongoing support to the family

d. ensure that all statutory obligations are met

e. learn lessons to reduce the risks of future infant deaths

1.3 When an unexpected death of a child or young person occurs, the body should be brought to the Emergency Department of the Hospital unless the Police decide the body cannot be moved or if there are already forensic medical examiners with the body. In some cases, it may be appropriate for the body to go straight to the mortuary, where it is felt that it would be extremely distressing to staff to view the body (e.g. severe trauma, death some time ago). There may be times when the Emergency Department is unable to facilitate the JAR process (due to workload). In these cases, moving the body to an alternative area (a Children's ward or Rowan suite) **MUST** be discussed with the coroner/coroner's officer in advance. His Majesty's Coroner (HMC) is happy to be contacted at all times in these circumstances (including out of hours – see contact information)

1.4 If the child comes from out of county proceed as you would for a child living in Somerset, but, if possible, contact their local GP, Children's Social Care or hospital medical teams in the area of residence as appropriate.

1.5 Resuscitation attempts in progress should be continued until the decision is made by the senior paediatrician or the Emergency Department consultant to cease.

1.6 In line with good practice, a nurse should be allocated to stay with the parents while continued attempts at resuscitation are on-going.

1.7 If parents wish to be present during resuscitation, then this should be supported, and the allocated nurse should stay with them to explain what clinical actions are being taken and ensure they are supported during these traumatic events.

1.8 A JAR should also be triggered for children (as under section 1), who are brought to hospital near death, successfully resuscitated, but are expected to die in the following days. In such circumstances the Joint Agency Response should be instigated at the point of presentation and not at the moment of death, since this enables an accurate history of events to be taken and, if necessary, a 'scene of collapse' visit to occur, even when the child has been transferred.

2.0 DEFINITIONS:

SUDIC: Sudden unexpected death in childhood

JAR: Joint Agency response

Strategy meeting: Multidisciplinary meeting including police, children's social care and paediatrics (as a minimum) and may also include pathologist

CSC: Children's Social Care

EDT: Emergency Duty Team at Children's Social Care

HMC: His Majesty's Coroner

APT: Anatomical Pathology Technician

Medical Certificate of Cause of Death (MCCD): This enables registration of the death, which in turn provides a permanent legal record of the fact and cause of death and enables people to make the relevant funeral arrangements.

Electronic Death Reporting Form (EDRF): the form completed in order to refer a patient to HM Coroner's Office sent electronically to HM Coroner's Office.

CDR: Child Death Review. The CDR process covers all children which is defined in the Children Act 1989 as a person under 18 years of age.

CDOP: Child Death Overview Panel

CSPR: Child Safeguarding Practice Review

3.0 ROLES AND RESPONSIBILITIES:

- **Lead Acute Paediatrician (or health professional):** Responsibility for initial resuscitation, informing parents, initiating JAR. Ensuring home visit occurs with police and attend strategy. Responsible for discussion and liaison with HMC. They may hand over to the designated doctor for child death if required after initial steps have been taken.
- **Designated Doctor for child death**: responsibility for supporting acute paediatrician, statutory role for coordinating responses to unexpected death.
- **Police**: Attend scene, liaise with paediatrician leading investigation, undertake investigation and attend strategy and home visit.
- **His Majesty's Coroner:** Has jurisdiction over the body until cause of death established and establishing cause of death. They are an independent judicial officer of the Crown who has a statutory duty to investigate the circumstances of certain categories of death for the protection of the public.
- **His Majesty's Coroner's Officers:** Supporting and acting on behalf of the coroner.
- **Bereavement and Medical Examiner office**: responsible for supporting liaison with Coroner, ensuring due process is followed.
- **Key worker**: Responsible for ongoing liaison with family and HMC/officer. This will usually be same as lead paediatrician, but may be delegated to an alternative person if they are better placed as know family etc.
- **Mortuary staff**: Care of the body and arrange transfer as required.

4.0 PROCESS DESCRIPTION:

4.1 Once death confirmed/resuscitation ceased

4.1.1 A lead health professional (key worker) should be assigned, as the point of contact for the family and to ensure all health responses are implemented. This will usually be the consultant in attendance at the time of presentation, or the child's usual consultant if they are well known to them (and that person is available in the next few weeks). This lead clinician is responsible for ensuring liaison with the coroner takes place.

4.1.2 The need for postmortem in SUDIC is paramount and every effort should be made to maintain the body in optimum condition by use of a 'cuddle cot' (cooling mattress) whilst investigations are undertaken, and the family spend time with their child.

4.1.3 The infant or child should be examined by the on-call consultant paediatrician as soon as is practicable. However, this examination should only be carried out once the (nonuniformed) police have arrived and agreed that it can be carried out. In cases where there are suspicious circumstances, the police may decide that forensic examination is more appropriate. Document findings in detail in the attached care pathway which should then be filed in the medical records.

4.1.4 The coroner gives consent for medical devices (ETT/IV lines etc) to be removed to facilitate parents saying goodbye. However, if these were felt to be relevant to treatment or there is concern, they should be left in place. Document in the body map the site of all medical interventions and detail in the report.

4.1.5 A full medical history should be taken from the parents or carers, ideally jointly with the nonuniformed police.

4.1.6 Other investigations should be taken either during the resuscitation attempts if appropriate (e.g. U&Es, blood glucose) or immediately after death is confirmed (see Appendix A for full details). The coroner has given formal permission for such samples to be collected after death.

4.1.7 **No Radiology should be acquired locally for an infant or child being transferred for PM at a tertiary centre.** Post-mortem skeletal and cranial imaging (either X-ray or CT) will be acquired at the tertiary centre, as part of the post-mortem process. The Pathologist conducting the PM will identify the imaging required which will then be reported by specialist Radiologists as part of that process. Where a PM is performed locally, any radiology requirement will need to be agreed as a direct

discussion between the Pathologist and a Consultant Paediatric Radiologist. Decision making should not be reliant on radiology results, as imaging examinations cannot be arranged out of hours i.e., outside Monday to Friday, 9am – 5pm.

4.1.8 Consider referral to Ophthalmology to identify retinal haemorrhages. If this is not possible due to corneal clouding/lack of ophthalmologist, post-mortem ophthalmology examination will be carried out by the pathologist.

4.1.9 The consultant paediatrician should inform the parents/carers of their child's death and include explanation of the need to inform the Police and Coroner, the necessity of postmortem examination and possible inquest, to try to establish the cause of death. All conversations should be clearly documented within the medical notes.

4.1.10 Ensure parents/carers have the opportunity to spend time with their child once resuscitation attempts have ceased and death is declared. This MUST be supervised at all times by a member of staff. Memory making is encouraged but should be documented precisely for the benefit of the pathologist and every care must be made to avoid any trauma to the body.

4.1.11 EDT, Police and coroner should be informed without delay, including out of hours.

4.1.12 For all deaths under 28 days – please inform Maternity governance team, and in addition the Labour ward coordinator, especially if still under community midwifery care. This will help ensure that community midwifery support can be put in place for parents, support suppression of breast feeding etc. Labour ward can also support with additional memory making if required.

4.1.13 There is a National Bereavement care pathway for Neonatal deaths. It may be appropriate for the key worker to refer to Somerset Management of Pregnancy loss.

4.1.14 When transferring a baby or child to the mortuary, it should be done in an appropriate and safe way to ensure that the body is kept in the same condition as it left the department so not to compromise any potential postmortem. For babies, they must **not** be transferred 'in arms'. They should be transferred using the specially designed transfer bag or a pram with waterproof cover which can be sourced from Maternity. For older children, they should be transferred in the same manner adult patients would be, in the concealment trolley. All transfers to the mortuary should be carried out by the portering staff however they can be accompanied by a member of the nursing team who have cared for the child.

4.1.15 Certain factors in the history or examination of the child may give rise to concerns about the circumstances of death. If such factors are identified, they should be documented and shared with the coroner and professionals in other key agencies.

4.2 INVOLVEMENT OF THE CORONER:

4.2.1 **The case will need to be referred to the Coroner as soon as possible.** Notification to HM Coroner should be in the form of an Electronic Death Reporting Form (EDRF). Medical practitioners must ensure that ALL fields are completed fully with the details requested. The electronic referral form can be found on the Trust intranet.

4.2.2 The coroner has control over the body from the moment of death, and no decision regarding moving the child anywhere other that Radiology or the Mortuary should be made without consultation with them.

4.2.3 The Coroner has agreed that the Emergency department should be the default venue for management of the child and family. If it is felt that ED is inappropriate (usually due to excessive workload) please see **Appendix J** for actions required.

4.2.4 **If it is necessary to move the body out of hours, or to deviate from this protocol, this MUST be discussed with the coroner by telephone *prior* to the event, otherwise submitting the EDRF is sufficient.**

4.2.5 Once complete the EDRF should be emailed to the Coroner at

a. **CoronersOfficersSomerset@avonandsomerset.pnn.police.uk** with a copy to the Bereavement office at **BereavementMPH@somersetft.nhs.uk** for cases at Musgrove Park or **BereavementYDH@somersetft.nhs.uk** for cases at Yeovil Hospital.

4.2.6 The coroner (in conjunction with the lead consultant, police and the pathologist) will decide if a standard hospital postmortem (e.g. teenage suicide) or a Home Office forensic postmortem (suspicious deaths) or specialist paediatric Post Mortem (SUDIC) is required.

4.2.7 There may be specific religious circumstances affecting the timing of the arrangements with this which would need to be discussed with the Coroner.

4.3 INITIAL INFORMATION GATHERING AND PLANNING MEETING AS PART OF THE JOINT AGENCY RESPONSE AND HOME VISIT:

4.3.1 This should be initiated by the on-call paediatrician and should involve all lead agencies including Police, Children's Social Care and any other relevant health professionals. **Please inform the Police and Children's Social Care of the child's death as soon as possible.** It may also include the Coroner's officer and any other health professionals on site who have been involved with the acute collapse or certifying the death. Other agencies may be involved as appropriate e.g. Child & Adolescent Mental Health Service, Prison service and Probation Ombudsman.

4.3.2 Police should be contacted as soon as a joint agency response is anticipated.

a) The non-uniformed Police from Operation Ruby should be used

b) Operation Ruby is staffed 8am-8pm

c) Where a death happens during the night duty, CID officers will progress the case with Operation Ruby staff taking over in the morning. Contact via police control room.

d) Operation Ruby contact address

1. OpRubySouth@avonandsomerset.police.uk
2. Somerset 01278 647549
3. Bristol, South Glos and BANES 01278 647546

4.3.3 In circumstances where a child has died, and abuse or neglect is known or suspected, professionals at the strategy meeting should agree:

a. if the criteria for a Serious Incident Notification by the local authority has been met

b. if a case for consideration needs to be submitted to the local safeguarding children partnership, for statutory partners to determine whether the case meets the criteria for a child safeguarding review.

4.3.4 During the strategy meeting, the senior investigating officer and the paediatrician on call will decide on the appropriateness and timing of a visit to the place where the child died or collapsed. This should always take place for infants and older children unless a forensic examination of the scene has already happened. Where the child has died outside the home it may still be appropriate to undertake a joint visit.

4.3.5 This visit should take place within 24 hours where practicable and is usually undertaken by the investigating Police officer and a Consultant Paediatrician. During this visit, the scene of death will be inspected, and discussion will be held with the parents to explain events up to that moment in time and also the structure of the on-going investigation. Further clinical/medical details may also be obtained if appropriate and documented in the attached care pathway.

4.3.6 Any additional information provided during this visit should be used to inform discussion between the lead agencies of the future management plan. Particular concerns regarding the possibility of non-accidental injury or neglect which may have contributed to the death should be considered and any risk to children remaining or in contact with the household.

4.3.7 A Key Worker (lead health professional) needs to be identified for ongoing support and communication with the parents and carers and to follow up health response and specimens

4.3.8 All deaths of neonates or children within the hospital setting will be subjected to a 'structured judgement review' which provides a rapid review of any needed learning.

4.4 PATHOLOGIST:

It is the responsibility of the lead paediatrician to provide the Coroner and pathologist with all information relating to the child's death and also any relevant medical history. **This information should also be relayed via a report to the Coroner within 48 working hours of the death**. Any information which is not available at this stage should be noted within the report to ensure appropriate actions can be completed. The Consultant Paediatrician immediately involved in the case should write a report of their findings and samples taken for the pathologist and the coroner.

4.5 OTHER RESPONSIBILITIES:

4.5.1 The Paediatrician should inform the patient's GP at the earliest opportunity.

4.5.2 The Paediatrician should inform the Somerset Child Death Review Co-ordinator who will then inform the Designated Doctor for Child Death. (see Contact details below).

4.5.3 Complete the notification of death on eCDOP https://www.ecdop.co.uk/PANDorsetSomerset/Live/Public

In addition, email: somicb.somersetchilddeath@nhs.net

4.5.4 The Child Death Review Co-ordinator will ensure other professionals working with the child are informed of the death e.g. vaccination programme, school

4.5.5 Inform the Named Nurse Safeguarding Children via: safeguarding@somersetft.nhs.uk

4.5.6 For deaths under 28 days inform the maternity governance team and head of midwifery as they will require a Perinatal Maternity review.

4.6 ONGOING ACTIONS AFTER INITIAL RESPONSE:

4.6.1 Once the preliminary results of post-mortem and examination are available, further discussion should take place between the lead paediatrician, pathologist and senior investigating Police officer. Subsequently, a further multi-agency discussion will probably be required depending on the circumstances of the individual case

4.6.2 Any information revealed from the results of the post-mortem examination which may indicate evidence of child abuse or neglect should prompt a referral locally for consideration of Child Safeguarding Practice Review

4.6.3 Once the final results of the post-mortem examination are available, a full child death review meeting should be held. This, of course, may be at any time from immediately after the post-mortem to 2-3 months after the death dependent on specimens being examined. The professionals involved in this meeting will be variable and will be dependent on the age of the CYP, and may include appropriate professionals from the acute and community setting as well as ambulance staff

4.6.4 This meeting is convened and chaired by the Designated Doctor Child Death. All information should be updated at this stage, onto the eCDOP system. Information from different professionals will be shared at this meeting and factors which may have contributed to or caused the death are then discussed. Future plans for the family are made and any potential lessons to be learned should also be identified. The outcome of this meeting will inform the subsequent inquest.

4.6.5 There should be clear documentation within the minutes of this meeting as to whether the possibility of abuse or neglect has contributed to or caused the death. If

that is the case, professionals at the Child Death Review meeting should agree who will submit a case for consideration for a child safeguarding practice review to the relevant safeguarding children partnership, if Children Social Care have not already completed a Serious Incident Notification. There should also be agreement of how information about the cause of a child's death is to be shared with the parents. Details of on-going support for parents/carers should also be included.

4.6.6 When abuse is suspected and/or Police are conducting a criminal investigation, the lead paediatrician should discuss with Children's Social Care, Police and the pathologist what information would be shared with the parents regarding the post-mortem. It would be good practice for the patient's GP to be party to these discussions.

4.6.7 A record of the case discussion meeting should be sent to the Coroner to inform if an inquest is required. The report should also be made available to the local Child Death Overview Panel (CDOP).

5.0 CERTIFICATION OF DEATH

Following the notification of a death to HM Coroner, and the completion of the investigation or Inquest process a Coroner's certificate of the Fact of Death will be issued and copies provided to parents. In certain circumstances when the death is unexpected but there are clear clinical symptoms and signs of a death from natural causes (e.g. epilepsy), HM Coroner **may** allow an MCCD to be issued. In any case where a cause of death can either be proposed to HM Coroner, or certified without coronial involvement, the death should be reviewed by a Medical Examiner (ME). The medical records should be sent to the Bereavement & Medical Examiner Office as per the Care After Death Policy and the case reviewed by an ME in order to provide an independent opinion of the cause of death. This ensures any cause of death proposed, or documented, is as accurate as possible and that the case has been reviewed in order to identify if there are any concerns regarding the care provided which need to be highlighted to the Learning from Deaths team.

MCCDs and cremation papers are held in the Bereavement and ME Office; this service can help in the completion of certificates and also ensure appropriate documentation is completed should cremation be required. They also provide additional practical advice and support to families.
Contact the Bereavement & Medical Examiner Office for further details or advice.

Musgrove Park Hospital – 01823 343753

Yeovil District Hospital – 01935 384746

For more details on certification of death see the Trust Policy:

Notification to HM Coroner, Medical Certification of the Cause of Death & Certification of Stillbirth.

6.0 CHILD DEATH OVERVIEW PANEL

The Designated Doctor for Child Death will be responsible for providing a summary of the child to submit to the Child Death Overview Panel. The panel

will examine the case and consider whether there are any implications for the Trust or public health arena. This process will be coordinated by the Child Death Review Coordinator.

The CDOP process is detailed in the Child Death Review Statutory and Operational Guidance 2018, available at Child death review: statutory and operational guidance (England) - GOV.UK (www.gov.uk)

7.0 FEEDBACK

Paediatric deaths including the outcome of the Child Death Review process should be discussed on a quarterly basis at the Paediatric/ED and Paediatric/Obstetric joint Mortality & Morbidity meetings.

Learning identified should also be discussed at Paediatric Governance and Paediatric Improvement Group meetings.

8.0 CONTACT DETAILS

Contact details (correct as of May 2024)

His Majesty's Coroner: contact via switchboard – ask for them to be contacted on their mobile out of hours.
Coroner's officer: in office hours call 01278 649 700.

Out Of Hours, the police act as the Coroners Officer.

Police:

Where a death happens during the night duty: CID officers will progress the case with Op Ruby staff taking over in the morning. Contact via police control room on 101.
8am-8pm: Contact Operation Ruby directly

OpRubySouth@avonandsomerset.police.uk

Somerset 01278 647549

Bristol, South Glos and BANES 01278 647546

Children's Social Care

Emergency Duty team: (available between 8am and 4am) 0300 123 2224

Mortuary

Musgrove Park Hospital - APT on call via switch board and in hours can be contacted on 01823 342299

Yeovil District Hospital - APT on call only on weekend daytime, contact via switch. In hours can be contacted on 01935 384332

Bereavement and Medical Examiner Office
Musgrove Park Hospital 01823 343753 (answer machine out of hours) or ext 4753/4957 (non-public numbers)
Yeovil District Hospital 01935 384746 (answer machine out of hours)
Designated Doctors for Child Death (available for advice)

Chris Knight:	01823 342693.	Christopher.Knight@SomersetFT.nhs.uk
Tamsyn Nicole	01935384775.	Tamsyn.Nicole@SomersetFT.nhs.uk

Safeguarding Children

Email:safeguarding@somersetft.nhs.uk

Strategic Lead and
Named Nurse
Safeguarding Children:
Nicole Mitchell 0300
323 0035

Child Death Review Coordinator

Generic email: somicb.somersetchilddeath@nhs.net

9.0 REFERENCES:

Sudden unexpected death in infancy and childhood -multi-agency guidelines for care and investigation The report of a working group convened by The Royal College of Pathologists and endorsed by The Royal College of Paediatrics and Child Health Chair: The Baroness Helena Kennedy QC 2016
Child Death Review Statutory and Operational Guidance DHSC & DfE 2018
Notification to HM Coroner, Medical Certification of the Cause of Death, Certification of Stillbirth & Cremation (Somerset NHS FT trust)

10.0 QUALITY ASSURANCE

Pan Dorset and Somerset CDOP panel review of each case

11.0 APPENDICES

11.1 APPENDIX A

Attached is the Integrated Care Pathway to be used in all cases of unexpected child death (0-18 years).
This is a PDF document so cannot be typed on.

A paper version is available in the ‘SUDIC’ box in the Emergency Department.

All paediatric consultants have a word version that can be filled in on computer.

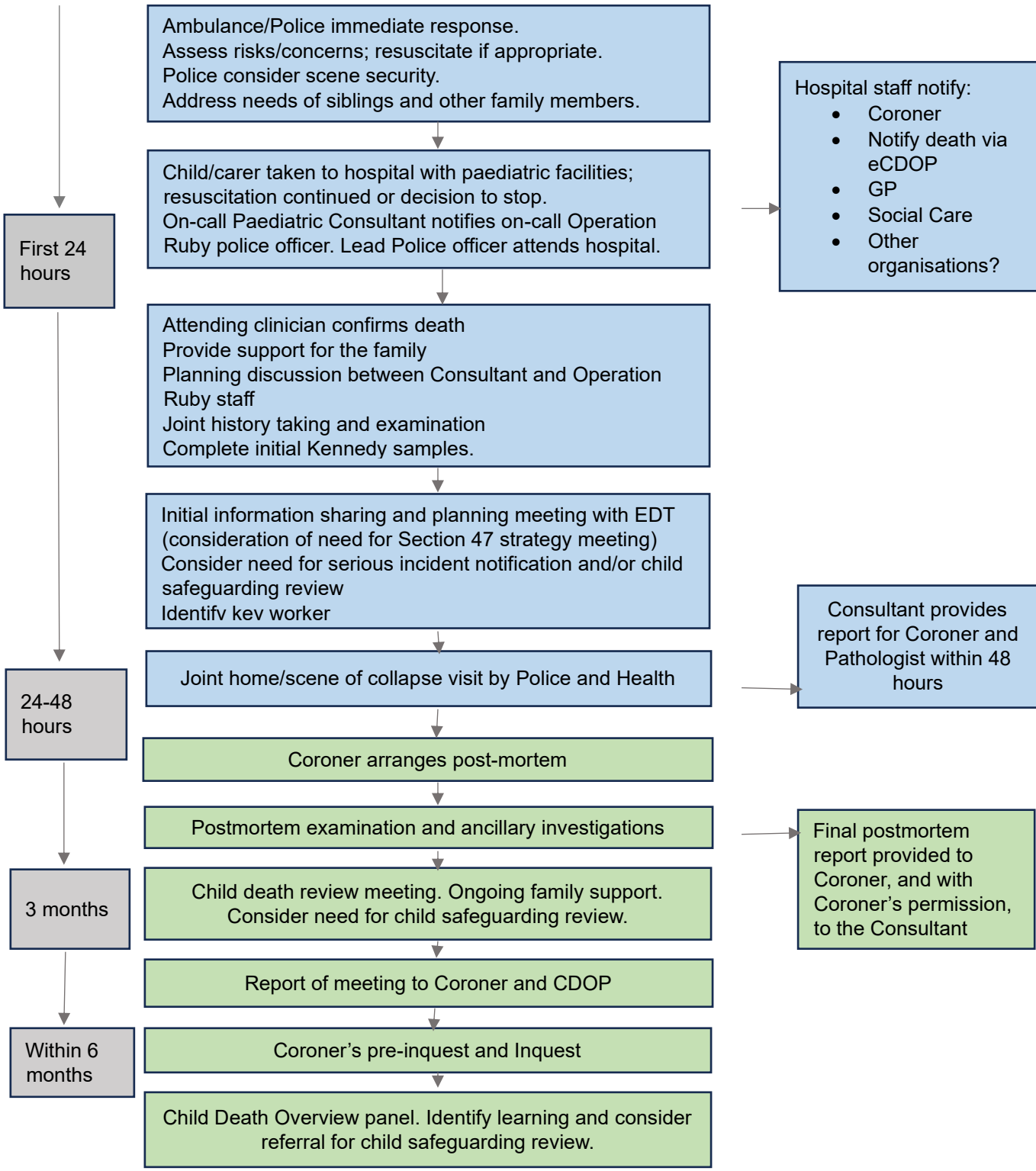
This document is available online via: Document details - Radar Healthcare

Paediatric Department

Integrated Care Pathway: Unexpected death in childhood (Joint Agency Response)

Complete all pages of the Integrated Care Pathway and file within patient's electronic patient record.

JOINT AGENCY RESPONSE



11.7 APPENDIX G

Bereavement Resources

2Wish: The optimal local provider for provision of support to all those affected by the sudden and traumatic death of a child or young adult aged 25 or under.
info@2wish.org.uk
01443 853125

The following are useful alternate resources for parents and siblings:

Bereaved Parents Support Organisations Network (BPSON): an umbrella body for organisations supporting bereaved parents www.bpson..org.uk
enquiries@bpson.org.uk

Bereaved Parent Support, Care for the Family: peer support for bereaved parents including a telephone befriending service
www.careforthefamily.org.uk/bps
0292 0810800

Bliss: Information and support for families of babies born prematurely or sick
www.bliss.org.uk hello@bliss.org.uk
0808 8010322

Child Bereavement UK: Training for professionals, support for families and a directory of local support services
www.childbereavementuk.org
0800 0288840

Child Death Helpline: for anyone affected by the death of a child of any age from any cause
www.childdeathhelpline.org.uk
0800 282986 or 0808 8006019

The Compassionate Friends: Peer support for bereaved parents and their families www.tcf.org.uk
0845 1232304

The Lullaby Trust: support for anyone affected by the sudden death of a baby or young child.
www.lullabytrust.org.uk support@lullabytrust.org.uk
Bereavement support line: 0808 8026868

Sands: For anyone who has been affected by the death of a baby
https://www.uk-sands.org/support
Helpline 0808 1643332

Survivors of Bereavement by Suicide: Support for people over 18 who have been bereaved by suicide
https://uksobs.org/
0300 1115065

TAMBA: Support for anyone affected by the death of a multiple www.tamba.org.uk/
0800 1380509
Support-team@tamba.org.uk

Support for siblings

Winston's Wish: supporting children and their families after the death of a parent or sibling
www.winstonswish.org.uk
0808 8020021

Cruse: offers support to bereaved children, young people and adults www.cruse.org.uk
0808 8081677

2Wish: provides support to all those affected by the sudden and traumatic death of a child or young adult aged 25 or under.
info@2wish.org.uk
01443 853125

Other sources of support:
There are also a number of useful organisations who hold information about the many smaller, specialised and local organisations available for bereaved families. One may be able to find a source of support more specific to an individual family through them.

Somerset End of Life Care
End Of Life (eolcare.uk)

The Childhood Bereavement Network
www.childhoodbereavementnetwork.org.uk

A Child of Mine
www.achildofmine.org.uk

At A Loss.org
www.ataloss.org

The Good Grief Trust
www.thegoodgrieftrust.org

Bereavement pack available from Medical Examiner and Bereavement Office in hours, and copies should be available in ED and on wards or through the Bereavement and Medical Examiner Office

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