Hampshire Safeguarding Children Board

Sudden and Unexpected Child Death and the Rapid Response process:

Information for Early Education and Childcare Providers

Introduction

The law requires that all sudden and unexpected deaths be reported to the Coroner and the Police if the cause of death is not natural, or is unknown.

In the sad event of your setting being notified of a child's death there can be ongoing actions and issues that need to be addressed. In some instances there will be a need for an immediate response during this deeply distressing time.

This leaflet gives an overview of the procedures that take place when a baby or child dies suddenly and unexpectedly and will help you to think about what support is available for you and your team and how you can support the child's family.

What is an unexpected child death?

Working Together to Safeguarding Children 2015 describes an unexpected death as:

The death of a child which was not anticipated as a significant possibility 24 hours before the death

OR

Where there was a similarly unexpected collapse leading to or precipitating the events which led to the death

What is the Rapid Response process?

The Rapid Response process is led by Health and Police services.

It is a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.

The purpose is:

- To establish, where possible, a cause or causes of death (in conjunction with the Coroner)
- To identify any potential contributory factors
- To provide ongoing support to the family

- To learn lessons in order to reduce the risks of future child deaths

What happens?

The rapid response process broadly takes place in three phases:

Immediate Reponses (sometimes referred to as Phase 1)

Health or Police colleagues will contact relevant professionals that are known to have had contact with the child, usually in the same day.

An Immediate Response meeting will be held (usually in the hospital) in order to gather information; including detailed and careful history and an assessment of the environment and circumstances of the death. This meeting is a similar to a safeguarding strategy meeting and it is a statutory responsibility to attend this meeting if you are invited.

You may be contacted to provide information about the child and their family.

Intermediate Response (sometimes referred to as Phase 2)

Another meeting usually takes place a week after the Immediate Response meeting; when the initial post mortem examination results are available.

All professional involved in this meeting share information about the child and future action plans are agreed. This may involve some actions for your service (for example: contacting the family to offer condolence; organising a memory book of the child's pictures and photos; or making a card from the setting).

Final Case Discussion (sometime referred to as Phase 3)

This usually occurs several months later when the final post mortem results are available. A final case discussion takes place between the groups of professionals who have been involved. A final report is completed and the Coroner decided if an inquest will be held.

This meeting is the closure of the Rapid Response process.

What is expected of you?

We understand that it can be a deeply distressing time and you may hear some potentially emotionally distressing details about the child's death. We acknowledge that self-regulating your own emotions at such time is very difficult. However, it is every family's right to have their child's death properly investigated and joint working is essential.

Therefore if you are contacted as part of the Rapid Response process it is essential that you:

- respond quickly
- bring information about the child and family *(Such as your observations about the child's development; general wellbeing; any incidents, accidents and safeguarding records or concerns; or details of other key adults)*
- contribute to the meeting and the provision of information in a calm and factual way
- maintain professional standards during the meeting
- identify and seek appropriate emotional support for you and your staff team before and after the meeting (Healthcare Needs and Critical Incident Guidance (2015)
- treat the contents of the meeting as confidential

How does this fit with the Child Death Overview Panel process?

The Rapid Reponses is part of a wider process of child death overviews, which is overseen by the Child Death Overview Panel (CDOP).

The death of all children under the age of 18 must be reviewed by a CDOP on behalf of the Hampshire Safeguarding Children Board.

Whoever certifies the death of a child has to inform the CDOP within 24 hours.

The CDOP then alerts relevant professionals who are known to have had contact with the child or their family.

For early education and childcare providers CDOP will contact Services for Young Children (SfYC), who will check the data base of children in receipt of early years education (EYE) funding. SfYC will then contact the setting to inform the setting of the death and offer support. The Health Care needs and Critical Incident Guidance for Early Years settings provides more details of the support available to settings (Healthcare Needs and Critical Incident Guidance (2015).

Please note: SfYC have no way to identify if children are attending an early years or childcare setting unless they in receipt of EYE funding.

Where there is a Rapid Response, it is likely to be underway prior to CDOP being alerted to the child's death. If you become aware of child death and you ***were not alerted*** by CDOP or SfYC please contact CDOP and SfYC immediately.

HCC.4LSCBCDOP@nhs.net

http://www3.hants.gov.uk/childrens-services/childcare/useful-contacts.htm

Some things for you to think about

- Where can you access support?
- At the Rapid Response meeting you will be required to share any information that you hold on the child and the family. What information can you share with staff and other parents who attend the setting?
- How are you going to tell other parents whose children attend your setting if this is appropriate?
- What role can you play in supporting the family and other children or siblings who attend your setting?
- How are you going to manage media (including social media) interest?

The Health Care needs and Critical Incident Guidance for Early Years settings provides more details of the support available to settings (Healthcare Needs and Critical Incident Guidance (2015)

Useful information

www.lullabytrust.org.uk 0808 802 6868

www.winstonswish.org.uk 08088 020 021

www.childbereavementuk.org or 0800 02 888 40 for more information.

www.cruse.org.uk or 0808 808 1677

www.itsgoodtotalk.org.uk British Association of Counsellors and Psychotherapists

www.simonsays.org.uk or 02380 647550

The Health Care needs and Critical Incident Guidance for Early Years settings (Healthcare Needs and Critical Incident Guidance (2015)