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Reviewing Childhood Deaths: Advanced training for rapid response teams

Resources to assist in the conduct of a rapid response to an unexpected child death, in accordance with Chapter 7 of Working together to safeguard children (2006)

(Throughout these materials the term *"investigate child deaths"* is used as synonymous with the term *"enquire into and evaluate child deaths"* used in *Working together to safeguard children 2006*).

These materials are intended to be used by professionals who have undergone initial training in the implementation and conduct of the rapid response to unexpected deaths of children as outlined in Chapter 7 of "Working Together".

Derivation of of these training resources

The information contained within these resources was derived from a study of professional "best practice" utilising the experience and expertise of professionals in all relevant disciplines throughout England, based upon the conduct of investigations after unexpected deaths of children, outlined in Chapter 7 of *Working together to safeguard children* (2006).

A small steering group with experience in investigating unexpected child deaths, initially including two members with expertise in each of paediatrics, health visiting, police, and social care, supported by a research team with expertise in epidemiology and population-based clinical studies was established in November 2008. Unfortunately, because of an unforeseen increase in workload the members with expertise in children's social care were forced to withdraw from the steering committee at a relatively early stage of the project, and although alternative contributors were approached and initially agreed to take part, they also had to withdraw before completion of the project. The input to this document from children's social care thus came predominantly from the contributors to the Delphi process and the pilot training days.The steering group planned, implemented and had detailed oversight of the results at each stage of the development of these training resources.

Professionals in all relevant disciplines (health, police, social care) throughout England, with experience and expertise in the conduct of investigations into unexpected deaths of children were invited in November-December 2008 to participate in a multi-stage Delphi process to derive agreed standards and recommendations for best professional practice in this field, and subsequently to take part in two multi-agency pilot training days utilising the materials produced.

During January-February 2009 a three stage iterative Delphi process was conducted, using a panel of 60 experienced professionals (15 police, 15 paediatricians, 15 children's nurses/health visitors, and 15 from social care & public health). Response rates were over 70% for each stage of the process, allowing the identification of those areas of practice that potentially caused the most difficulty as well as those within which there was a clear professional consensus of what constituted best practice.

The resources that follow are derived from the results of this Delphi process, together with further feedback obtained from the 65 participants in the two one day multi-professional pilot training days held in February and March 2009 utilising these materials and the related presentation and case-based training materials (which had also been derived by the members of the Steering Group from the results of the Delphi process).

In total more than 120 professionals have contributed to the material contained within this document, which thus represents a broadly based multi-agency professional assessment of "best practice" in the investigation of unexpected deaths in childhood in England in March 2009.

We are very grateful to the many professionals who contributed to this very time-consuming process and who freely shared their experiences and expertise in the development of these training resources.

The purpose and planned use of these training resources.

This document is intended to be used by professionals involved in the multi-agency rapid response to unexpected deaths of children as required under the statutory guidance to the Children Acts 1989 and 2004 respectively (Chapter 7 of *Working together to safeguard children* (2006).

These resources will constitute a reference source for recommended or best practice in the conduct of these investigations, and are intended primarily for use by professionals who have completed initial training in the rapid response process – either by completing the one day training course on the rapid response process published by the Department for Children, Schools and Families (http://www.everychildmatters.gov.uk/socialcare/safeguarding/childdeathreview/trainingmaterials/) or the three day Advanced Course in the investigation of childhood deaths at the University of Warwick.

In addition to use as a reference guide, these resources are intended to constitute the required pre-reading for participants attending the one day Advanced Course in the rapid response to unexpected child deaths. This course has been designed and developed for professionals with a continuing involvement in the implementation and running of the rapid response process in their local area.

It is anticipated that the content of these resources will evolve and develop as professional knowledge and experience in this field develops.

In its present form this document is valid for use from March 2009, but as for all practice-based guidance should be subject to detailed review after 2 years (March 2011), by which time there will be a total of 3 years experience in the implementation and conduct of these statutory processes.

Peter Fleming,
Chair,
Project Steering Committee.
March 2009.

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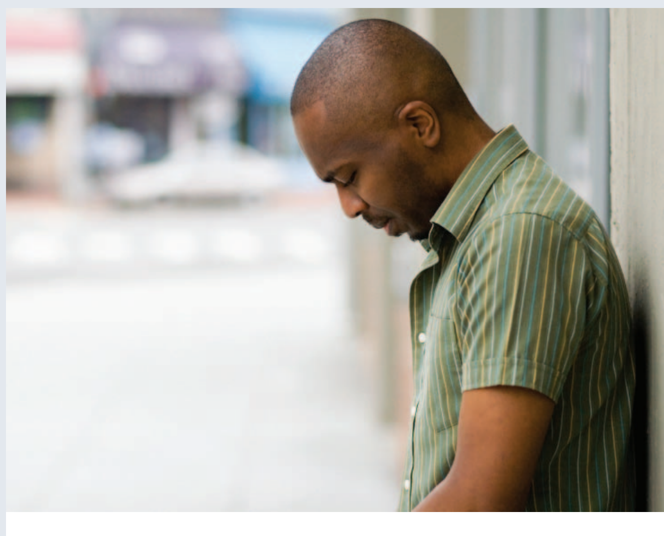


1. Initial presentation of unexpected child deaths to professional attention

a) Particular responsibilities of the professional initially attending when the child is thought to have died.

This may be a first responder – e.g. ambulance or police service), a member of the primary care health team (e.g. GP, Health visitor), staff in a hospital emergency department, or other health or social care setting.

It is essential to emphasise that the first, most important and urgent responsibility in such circumstances is the resuscitation of the child if at all possible, with care of those with the child as the second priority. The investigative role, although important is always secondary to the protection of life and health.

On being informed that the child is dead:

1. Examine him/her to confirm whether the child is dead - if uncertain then commence or continue resuscitation as appropriate.

2. Remember that you are responsible for ensuring the right things happen until you have handed over the care of the child and family to another appropriate professional.

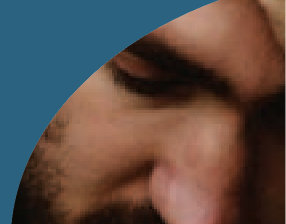
3. For children undergoing palliative care at home or in a hospice and for whom the death has been anticipated, resuscitation will not usually be offered. These deaths should not usually be considered as unexpected and the rapid response process is almost always unnecessary and inappropriate (but see sections 1:b.7 and 8, below).

4. As soon as possible alert the appropriate agencies involved in the rapid response process (this always includes police, health and children's social care, and in certain circumstances other agencies may also be involved – e.g. transport police, coastguard, education, Health and Safety Executive).

5. As part of this immediate notification process you should notify the police immediately of any obvious suspicions or evidence of a non-natural process leading to the death.

6. Unless you think you are dealing with a possible homicide, arrange immediate ambulance transfer of the child and carers to the nearest hospital emergency department with facilities to care for children (in order to ensure rapid ambulance transport it may be helpful to consider that the distraught parent or carer and/or siblings are "patients" needing help and support from the health care system).

7. Except in the case of suspected homicide, ambulance crews should routinely take all children who have died unexpectedly to the nearest hospital Emergency Department with facilities to care for children rather than taking them directly



to the mortuary. This will ensure that the relevant professionals are promptly informed to instigate the rapid response process, and the family are given appropriate help and support.

8. Carefully observe the scene and circumstances and record your observations.

9. Where possible minimise disruption to the scene (sympathetically).

10. Carefully observe or examine the child (within your professional competence), and note the position and place the child is lying, and whether he/she has been moved. Note where he/she was when initially found.

11. As far as possible note and record all procedures (e.g. resuscitation procedures, insertion of intravenous lines etc) carried out at all stages – both before and after arrival at the hospital Emergency Department.

12. Carefully document all of your observations including what is said and done by you and anyone who is present.

13. Identify potential witnesses to what has happened and if possible obtain contact details.

14. Include verbatim notes of what is said as far as possible.

15. Gather brief details from the parents/carers (child's details – name, age; brief history of events – how & when child died/was found; any previous illness; any medication).

16. Collect details of parents/carers/other household members/others who are present.

17. Note demeanour, presentation and behaviour of carers and record this but do not draw conclusions from these observations.

18. Inform parents/carers of what is likely to happen next, and what may be required of them. This may need to be repeated many times, as in these circumstances the parents may not be able to take in much of what is being said to them.

19. Provide or ensure someone else provides continuing support to parents.

20. Inform the parents that a police officer and health worker will attend to speak to them and to explain why this is necessary.

21. On arrival at hospital ensure a nurse is allocated to the family to provide continuity of support and care to them throughout the hospital procedures.

22. Ensure the family know that health professionals and/or police will wish to talk to them before they leave the hospital. It may not be appropriate to keep distressed parents waiting in an emergency department for a long time if the police or paediatrician is delayed – but make sure you know where the family will be, and how to immediately contact them (e.g. mobile and home phone numbers of family members and any friends who are with them).

23. Ensure children's social care are informed and asked to check on any knowledge or involvement with child or family.

24. If the police decide to "seize" or remove any item from the child, the environment of the death, or the scene of resuscitation this must be very carefully documented and recorded, as well as the reason for doing so.

25. It is of the greatest importance that you hand over carefully and thoroughly to other professionals before leaving. This includes transfer of all information collected from observations, discussions with the family or others involved, and information on the names and contact details of all involved, as well as ensuring that appropriate provision is made for continuing support and care of the parents or carers.

b) Categories, circumstances and types of child death that warrant a rapid response

1. Deaths from road traffic collisions.

2. All forms of trauma, fire, drowning or other physical external causes of death.

3. Any apparent suicides or homicides. (It is important to note that recent manslaughter legislation takes a wider view of culpability, including professional culpability – if in doubt it is important to discuss this as part of the multi-agency review).

4. Unexpected death from illness or sudden collapse leading to death of a child who prior to the collapse or sudden illness had been thought by those caring for the child to be healthy or well.

5. Unexpected death or sudden collapse leading to death where the child was thought to be well less than 24 hours before the collapse though he/she may have been recognised as being unwell at some point before the collapse or death.

6. Death of a child with a known illness or medical problem of more than 24 hours duration, but who was not thought by those providing care (parents and/or professionals) to be at risk of dying in the near future.

7. A child with a known life-limiting or life-threatening condition with a known risk of sudden death but where the circumstances of the death were unexpected (i.e. the child was thought to be at risk of death, but not yet or not in these circumstances).

8. For the sudden death of a child with a known life-limiting or life-threatening condition it may be helpful to ascertain whether any end-of-life planning or agreements were in existence, and whether the circumstances of the death led to implementation of this end-of-life plan. Such information may be of great value in ascertaining whether a rapid response is required.

9. Any death of a child where any aspect of the circumstances or history raise suspicions that this may not have been a natural process.

10. Sudden or unexpected deaths of infants within a few days of birth – sometimes before discharge from hospital – require very careful consideration by the healthcare professionals involved. Collection of information from other agencies will usually be required, and consideration should be given to whether a full multi-agency rapid response investigation is required. Although such deaths are very rarely the consequence of deliberate abuse or neglect, the wider interpretation of the rules on culpability in recent legislation on manslaughter means that in many such instances a discussion should take place between senior professionals in the three key agencies – police, health and social care to decide the nature, timing and extent of the required investigation. It is important however for police and social care professionals, who will have little experience of perinatal care, not to over-react to such deaths and to be guided by the healthcare professionals. It is also important that healthcare professionals recognise that occasionally such deaths do warrant a full multiagency investigation.

11. Similar considerations apply to unexpected collapse and death after a surgical operation. Such deaths must always be thoroughly investigated within the healthcare setting, but it will seldom be appropriate or necessary to institute a full multiagency investigation.

c) Circumstances in which a rapid response process is required, but the emphasis or profile of the response may be modified because of the circumstances of the death.

1. If there are immediate suspicions of homicide/suicide, then police will take the lead, social care may have a major role and health professionals' involvement may be less, but all agencies must still be involved.

2. For all unexpected child deaths it is important to start "comprehensive" with the early involvement of all potentially relevant agencies – provision of initial information to and collection of information from all agencies quickly will allow a decision to be taken on which agencies should be involved in the rapid response. It is better to collect information widely and then scale down the response rather than the other way round.

3. Deaths from trauma – for these deaths it is important that appropriately qualified and trained professionals conduct a thorough investigation of the circumstances at the scene of the death and a multi-professional or multi-agency visit to the scene may also be helpful in some circumstances and should be considered if it is thought likely to add further information.

4. In the case of deaths from trauma in the home environment it is also important that the initial investigation of the scene and circumstances is conducted by professionals with appropriate training and expertise. In some such circumstances there may be particular value in the involvement of a paediatrician or other health professional with knowledge and understanding of the particular abilities and vulnerabilities of infants and children at different ages.

5. A home visit by a health professional should be considered if it is deemed likely that such expertise may be of value in interpreting the events and circumstances of the death.

6. A home visit by a health professional may be of great importance in helping to support and provide care to the family regardless of the skills required for interpretation of the circumstances of the death. This role will usually be best filled by the primary healthcare team, but initially (particularly out of normal working hours) the healthcare members of the rapid response team may have an important supportive role for the family.

7. Road traffic collisions – the main investigation of scene and circumstances will be by police traffic collision investigators.

8. Unexpected or sudden deaths in institutions, e.g. hospitals, residential schools, young offenders' institutions where a specific investigation related to the nature of the institution should be promptly initiated but the relative contributions from the agencies and professionals involved may differ from the standard rapid response process. All agencies should still be involved initially.

9. For the deaths of children with known life threatening illness or life limiting conditions, the main input will usually be from health services, but other agencies must be informed and involved whenever appropriate. The level of input from other agencies will be partly determined by the degree to which the death was a possible anticipated outcome at some time, an outcome anticipated in the near future, or an outcome not previously anticipated as a significant risk (see points 4 – 8 in the section above) .

10. Where a cause of death becomes obvious at an early stage – e.g. a sudden collapse in which evidence of meningococcal sepsis is apparent on examination of the body and can be confirmed by initial investigations, there is less requirement for police to be directly involved, but unless the diagnosis is certain before the time of death, the death should be discussed with the police officer on duty for the rapid response process; a similar approach may be appropriate where there is evidence on history of a seizure that may have led to death in a child with known complex epilepsy. Discussion with the police and children's social care in this setting does not necessarily lead to a full rapid response being implemented unless other aspects of the information obtained cause concern about possible neglect or abuse.

11. It is important for there to be liaison between relevant professionals as soon as possible to agree the objectives and priorities in all investigations.

12. The early involvement of all relevant agencies should take place regardless of the seniority of the person involved initially from the agency first contacted. It is not appropriate for delay in passing information up the chain of command within one agency to delay or prevent appropriate multiagency working. It is however not a requirement that all aspects of the rapid response process (e.g. the home visit) are always and immediately implemented. The involvement of senior staff in each agency should occur as soon as possible where there is any doubt about what should be done in terms of the rapid response process.

d) Scene Preservation

1. As noted previously, resuscitation takes priority over ALL other aspects of the process including scene preservation.

2. Scene preservation is the responsibility of the professionals first on the scene although will be handed over to the police when they become involved.

3. The police are ultimately responsible for scene preservation

4. The nature of scene preservation will depend on the circumstances but must not interfere with appropriate efforts to protect life or safety

5. Scene preservation needs to be considered early in all unexpected and unexplained deaths; where there is any significant concern of possible abuse/homicide/suicide this must be considered and implemented urgently.

6. Informing the relevant agencies as early as possible and initiating the rapid response process will facilitate preservation of the scene, as it will allow the rapid response team members to meet and talk to the parents or carers as soon as possible after the death. For teams covering a large geographic area, in which travelling times may be considerable it is important that the rapid response team members have the opportunity to attend the hospital emergency department before the family leave if possible.

7. Whenever possible for non trauma-related deaths scene preservation should be by non-uniformed police in unmarked cars (but this is not feasible or appropriate for trauma-related deaths – e.g. road traffic collisions).

8. Consider obtaining keys to the home and ensuring no unsupervised visits prior to a scene review. This may cause disruption or difficulty for other family members, so should only be done where there are significant concerns about the circumstances of the death, or where family members do not initially wish to return to the home (e.g. single parent who wishes to return to the home of another family member or a friend). Many parents (particularly single parents) do not immediately wish to return to their home if this was the scene of the child's death – and some do not ever wish to return there, so do not attempt to coerce parents into returning if they do not wish to do so.

9. Routine seizure of items from the room in which the death has occurred may reduce the opportunity to adequately investigate what happened – e.g. routine seizure and removal of bedding and or clothing after SUDI has virtually no evidential value, whilst leaving such items in place pending a full multi-professional home visit may allow the circumstances and events leading up to the death to be thoroughly investigated.

10. Encouraging the family and members of the household to attend the hospital with the child who has died will serve the double purpose of protecting the scene and ensuring that these individuals receive appropriate help and support from the relevant professionals.

11. For deaths at home, encouraging the family or other members of the household who are not accompanying the child to hospital to leave the room or sometimes the building (provided an appropriate place can be identified for them to wait) pending further investigation may be important in assisting scene preservation.

12. In road traffic collisions scene preservation is generally the responsibility of traffic collision investigators.

13. In other deaths outside the home, a more robust approach to scene preservation may be required to ensure the public do not contaminate the scene – this will depend on the circumstances.

14. The important issue is to have procedures and systems in place to enable relevant professionals across agencies to collaborate as early as possible and decide upon a strategy which can seek to achieve as many relevant objectives as are possible.

e) The wide range of possible circumstances in which a death may have occurred will influence the initial response: Suspicious or possibly suspicious circumstances may lead to different approaches to those adopted in circumstances strongly suggestive of a natural cause.

1. The "typical" presentation of sudden infant death in a cot of a previously well child (or one who has experienced only minor illness recently) in a family with no relevant social, police or medical history will usually lead to a "standard" SUDI multi-professional investigation. Although in the past most sudden unexpected infant deaths fitted this pattern, the fall in numbers of such deaths in less deprived families in recent years means that such a presentation is now relatively uncommon.

2. A similar death in which there is evidence of previous child neglect or abuse (of this child or other children), evidence of parental alcohol or drug use and sleeping arrangements suggestive of physical or other hazards to the child should also lead to a "standard" investigation but the balance of involvement of the various professional agencies may be different. It is important to recognise that families in which social, crime, drug or alcohol related problems have occurred are at increased risk for natural causes of infant or child death – as much as for deaths related to inappropriate care, direct harm, abuse or neglect.

3. If the initial information exchange between agencies raises significant suspicions of possible abuse/homicide/suicide, then the police will take a stronger lead and are likely to exclude all others from the scene of death or collapse until a forensic investigator has reviewed the scene.

4. In most other circumstances, discreet scene preservation can be maintained until a joint (health and police) assessment is undertaken.

5. Although in some circumstances the police may require a forensic investigator to take photographs/videos samples as part of a scene examination and other measurements of the scene pending a later home visit, such photographs will usually be best directed by information arising from the joint home visit.

6. If significant suspicions of neglect or abuse are raised from the initial presentation, there must be an early multiagency review of whether the initial history may need to be taken from both parents separately, and/or by a police officer rather than a paediatrician. (This may have to be a formal interview in line with provisions of Police And Criminal Evidence Act 1984.)

f) Tasks required in the immediate stages after an unexpected child death, and who should be responsible.

General:

1. It is important to have known single points of contact for each agency and standard well-developed inter-agency communication agreements. Early inter-agency communication is important.

2. Good communication between ambulance and police control rooms is crucial to ensure prompt notification of the rapid response team.

3. Contact with the social care emergency duty team (EDT) should be as soon as possible, and the EDT should have the ability to promptly make contact with relevant professionals within children's social care.

4. It is important to remember that the great majority of unexpected deaths of children are NOT suspicious, so professionals should not over-react.

Specific:

5. The most senior medical professional present should confirm that the child is dead – (paediatrician / A&E doctor / police surgeon / GP).

6. The most senior medical professional present should take an initial history from the parents/ carers – (Paediatrician - ideally with a police officer present).

7. The most senior medical professional present should examine the child – (paediatrician - ideally with a police officer present).

8. Initial laboratory samples should be taken with careful recording of process and attention to ensure continuity of evidence – it is important to ensure that routine labelling and transport of such samples in the hospital Emergency Department is sufficiently careful and thorough to provide adequate evidence of continuity – (paediatrician).

9. The most senior medical professional present should document any findings on initial examination – (usually the paediatrician, but may be an Emergency Department doctor).

10. The most senior medical professional present should inform the parents/carers of the fact of death and any initial pointers to a possible cause of the child's death – (paediatrician with nurse support).

11. Background checks on the family and all persons having relevant recent contact with the child should be undertaken as soon as possible – (police).

12. Clean and dress child as appropriate – with photographs first if necessary – in circumstances in which there is significant suspicion of a non-natural cause of death this should not be done - in these circumstances the child should be covered with a blanket, the child should not be cleaned, and the clothing should be disturbed as little as possible except for resuscitation – (A&E/ paediatric nurse; police to photograph if necessary).

13. Offer photographs / mementos – these should be discussed with the parents, but in circumstances in which there are significant suspicions this may not be appropriate. – (nurse providing continuity of care).

14. Inform the coroner and others involved in rapid response process – (police and paediatrician).

15. Inform primary care team (GP and /or health visitor), child health service and CDOP – (nursing and / or medical staff).

16. Offer bereavement/religious support, contact numbers, leaflets – (A&E/paediatric nursing or medical staff).

17. Scene preservation – (police).

18. Commence preparation of report for pathologist – (lead health professional and police).

19. Arrange initial information sharing and planning meeting/discussion – (paediatrician/ police / social care).

20. Arrange home / scene visit – (police and paediatrician sometimes also social care).

Information from first responders and others present

21. Joint discussion by police and healthcare professionals with first responder as soon as possible after arrival will help ensure accurate and detailed information is collected (Procedures must be in place to capture such information on all occasions).

22. The medical aspects of the history from the first responders (and from the parents or carers) are best collected by healthcare professionals whilst the police help review any information given in terms of its potential indication of a non-natural process.

23. Describe the scene and site of the child's death in as much detail as possible. Include information on temperature, light levels, heating, objects in the environment (e.g. furniture and furnishings if indoors), position, place and actions of people in the environment at the time of arrival of the first responders.

24. Make a careful record of who was present at the time of collapse/injury/ death.

25. Note what was said (verbatim if possible, though this is very difficult in the stressful circumstances of an unexpected child death).

26. Any specific concerns or unusual observations made by the first responders.

27. Additional information provided by household members, other relatives, visitors or anyone else in the vicinity of the unexpected death should be documented as accurately as possible. It is important to identify as carefully as possible the origin and basis of information collected in this way – there is little benefit from collecting "idle gossip".

Leadership and lines of responsibility

28. It is Important that the most senior member of each profession/agency liaises quickly with representatives of other agencies and agrees roles and responsibilities.

28. The agency taking the lead responsibility may vary according to the level of suspicion by the professionals involved about the possibility of an unnatural event, or their perception of the level of probability that the death was a natural event.

29. The question of leadership and lead roles is most commonly more a question of identifying which agency should take the lead in which aspects of care and investigation.

30. Good communication between agencies and within agencies is very important and recognition that information can be shared between agencies is very helpful.

g). Possible indicators of non-natural causes of unexpected child deaths: Each of these indicators may raise questions, but none on its own - or in combination is direct evidence of a non-natural cause.

(It is important not to over-react to any of these observations, but to review them carefully as part of the multi-agency process)

1. Unexplained delays in seeking help.

2. Major inconsistencies or variability in the history as presented by the parent or carer.

3. A history that does not fit in with the observed findings – e.g. examination findings of injury with no explanation or an explanation that does not seem to fit the injuries.

4. Circumstances or history which seem inappropriate to the child's age or developmental abilities.

5. Unexpected or apparently inappropriate comments by parent, carer or other member of the household.

6. Child already known to professional agencies as suffering or likely to suffer from significant harm (neglect or abuse).

7. Overt suggestion of a non-natural cause by a member of the household, family or friends.

8. Evidence of substantial recent alcohol/drug use by the child, parent carer or others in the environment – smell, demeanour etc.

9. Concerns or evidence of impaired mental health in a parent, carer or child.

10. Evidence of domestic violence (bruises or other injuries to either parent).

11. Significant learning disabilities in parents. This will require very careful assessment of the history and description given by the parents and it is especially important to ensure the parents understand what is happening and are given appropriate support.

12. **NB:** There is no "normal" pattern of behaviour or grief, so whilst it is important to document what is said/done, as well as the way it is said or done, it is important not to over-interpret unusual ways of responding by parents or carers.

2. Initial professional assessment (including history taking and information gathering

It is important that all professionals involved in the multi-agency investigation of unexpected child deaths understand not only what skills they themselves have, but also recognise the particular skills and knowledge members of other professions are likely to bring. Mutual recognition and respect for the skills contributed by each profession is likely to lead to improved understanding and more effective inter-agency communication during the often highly stressful process of investigation of an unexpected child death.

a) Specific professional knowledge and skills

I All professionals

1. Compassionate and respectful approach to the family, combined with a degree of respectful scepticism.

2. Knowledge and understanding of the rapid response process and the reasons for conducting it.

3. Experience and training in working with families in the home.

4. Listening skills/ability to empathise.

5. Ability to make assessments, provisional (but not fixed) interpretations of limited findings and decisions in sometimes chaotic/distressing situation.

6. Ability to assimilate information in difficult environments/ circumstances.

7. Clear understanding/respect for other agencies involvement and roles.

II Police

8. Skills in interviewing in a non-leading way: particularly in interpreting the nature and style of responses and their possible relevance (but it is important not to over-interpret variations in responses between individuals).

9. Identifying concerns about non-natural causes.

10. Identifying the consistency of information given.

11. Confronting parents with concerns where appropriate (according to PACE rules) – may also use interview advisors to assist this process.

III Social care professionals

12. Skills in lateral checks, identifying sources of information.

13. Knowledge of social and cultural variations within a community.

14. Knowledge of local community structure.

15. Important to also check records of all other family and household members.

IV Healthcare professionals (nursing)

16. Accurate and consistent recording of information is a key feature of nurse and health visitor training.

17. The rapid recognition and assessment of the particular needs of the respondent (e.g. parent or carer) is also a core feature of nurse and health visitor training and may facilitate better communication and improved information gathering by the professionals involved.

18. Health visitors have extensive knowledge of patterns of child care and variations in practices within different social and cultural groups.

19. Taking a history with regard to normal child development and patterns of illness is a core skill of Health Visitors. History taking that is guided by the process of making a diagnosis, and the diagnostic approach to the assessment of information gathered is however not a core part of nurse and health visitor training and thus specific and explicit training in this area needs to be given in order for nursing professionals to effectively carry out this role.

V Healthcare professionals (paediatricians)

20. The conduct of a thorough, semi-structured, flexible, medically oriented interview focusing on a diagnostic approach to understanding what may have caused the death including aspects of the child and family's medical and social background is an essential component of paediatric training.

21. The recognition and investigation of circumstances and behaviour suggestive of neglect or abuse is also a key component of community paediatric training, and it is important that these skills are required of all paediatricians involved in the rapid response process.

22. An understanding and knowledge of developmental attainments of children of different ages, a recognition of what is or is not feasible or likely to have been done by a child of a particular age and an understanding of particular medical and physical vulnerability of children of different ages are also key components of paediatric training.

23. Skill in the physical examination of children and in interpreting findings.

b) The collection and recording of relevant information (including samples that may be required)

1. There may be value in establishing a new set of records specifically dealing with the child death investigation process in each agency. Such a record should immediately contain a copy of all that is in the original agency record for that child, but will also contain information about other family members, household members, or others involved in the investigative process, and will thus need to be accorded a higher degree of protection from inadvertent disclosure than normal records. If all agencies used a similar format for such records this would facilitate the sharing of information and effective communication between agencies. Such a record should contain aide-memoire lists to facilitate appropriate investigation for specific categories of childhood death – e.g. SUDI, road traffic collisions, trauma in the home.

2. A careful record should be kept (e.g. in the form of an investigation log used by the police) not only of what is done and not done at each stage and time of the investigation, but the reasons that particular decisions concerning any aspect of the investigation were made.

3. Information on procedures, process and the necessary or recommended samples to be taken in certain circumstances should be immediately available in all emergency departments dealing with children.

4. Lists of appropriate samples to be taken after Sudden Unexpected Death in Infancy *(Reference: Sudden Unexpected Death in infancy: a multi-agency protocol for care and investigation 2004 [http://www.rcpath.org/index.asp?PageID=455])* have been agreed nationally and should be considered as the basis for samples in other unexpected deaths in childhood although clearly not all will be relevant.

5. An early complete skeletal survey should be considered in all cases and carried out as soon as possible, preferably with the report being prepared by a consultant paediatric radiologist. Few postmortem rooms have facilities to undertake X-rays of sufficient quality to satisfy the requirements of a child protection skeletal survey. Delaying X-rays until the postmortem may lead to an unacceptably long period before recognition of whether or not fractures are present. Where a decision is taken not to

perform a skeletal survey, the reasons for making that decision should be discussed between the relevant professionals and carefully documented.

6. Senior professionals in each agency should be involved as soon as possible – it is not appropriate for junior staff members to be required to make the difficult decisions about the conduct of such enquiries.

Inter-professional communication and agreement on the approach to history taking

7. Roles, responsibilities and approaches to information gathering should be agreed as far as possible before the first detailed discussion with the family or other members of the household or other people involved. Locally agreed standard formats for such agreements should be in place to ensure consistency and effective working. This is likely to be of particular importance on those occasions when the individual members of the rapid response team have not worked together before.

8. It is generally better for professionals to seek answers to questions within their own fields of professional expertise, e.g. health professionals should ask about health-related issues whilst police may be better placed to ask questions related to hazardous activities, behaviour or observations suggestive of the possibility of abuse or neglect.

9. Careful recording of verbatim responses is very important and observation of how information is given as well as the nature of the details given by the parents or carers.

10. Sometimes the parents may not be the most appropriate people to obtain a history from, either because other people or witnesses may have the relevant information or because there are forensic or legal considerations particularly if there are any suspicions about the cause of death. Such information may include personal information relating to the third party, and must be treated accordingly. The use of a specific "child death" record (see section b1 above) – distinct from the normal agency patient or client record – may facilitate disclosure of sensitive information, as it may be more easily protected from inadvertant disclosure.

The approach to history taking

11. The history should ideally be taken by an experienced paediatrician or a specially trained health visitor or nurse together with an experienced police officer.

12. There is a need for a compromise between a strictly structured, protocol-led pro forma style of information collecting and a completely free unstructured approach.

13. The best compromise may be to allow parents or carers to present information in their own order and in their own words, with careful prompting by the attending professionals to ensure there are no significant gaps in the information collected and to ensure that possibly ambiguous or unclear descriptions by the family are clarified in unambiguous ways.

14. It is important to avoid "leading" questions.

Recording of the history

15. The history should be recorded as thoroughly as possible by the most senior professionals present.

16. Notes should include verbatim information wherever possible, particularly if unusual or possibly ambiguous forms of words are used.

17. The history will usually be taken from both parents together, unless there are significant initial suspicions, or unless one parent requests or intimates that he/she would prefer to be spoken to alone.

18. The history must be recorded in a structured and legible form, signed, timed and dated and preferably eventually provided in a typed format.

19. It is important to have the opportunity to add extra information later – parents often remember important information later. It is also important that information added later can be immediately identified and the timing of such additional information is accurately recorded.

Use of a pro forma or aide-memoire

20. The disadvantages of pro forma based information collecting include rigid structure, forced order of questions, difficulty in maintaining eye contact between questioner and the person being interviewed, and less fluency in description by someone who is being forced to give a history in an order different to that which they would prefer or give spontaneously.

21. The advantages of an aide-memoire list are that it allows the individuals to use their own words and encourages eye contact. It ensures that areas not perhaps included in the pro forma may still be included in the history but it ensures that all areas usually deemed to be important are covered.

22. A single format of record keeping by the different agencies would have some advantages in the final interpretation of the available data but in the absence of a single unified digital record even within each agency this is not achievable at present. A common format (as outlined above) may be helpful.

23. Information sharing is crucial to ensure that all relevant information is contained within each agency's records.

Joint review of the history by different agencies

24. This should be a continuing process, not a single event.

25. Close communication requires frequent information sharing between the lead professionals in each agency, and careful sharing of new information that may become available from one agency or another.

26. The decision should be to have frequent careful sharing of information and the decision not to share information should only be taken in exceptional circumstances and the reasons for doing so recorded. Whenever such a decision is made, the other agencies must be made aware that information is not being shared – they must not be allowed to assume that because information is not being shared there is no information to possibly share. Even when a decision has been taken not to fully disclose all information to all professionals in other agencies (and such a decision must only be taken at a very senior level), some sharing of information will almost always be appropriate between senior professionals in the different agencies.

Specific communication skills, interview text and conversation management approaches for multi-agency information gathering

27. The police have considerable experience of communication or conversation management techniques and in health professions, the same approaches form part of good clinical history taking but there is little experience and no published data on the development of appropriate multi-agency techniques for use by individuals with widely different professional backgrounds.

28. Understanding and knowledge of the principles involved in helping to guide interviews/history taking and mutual understanding of the principles being followed by the different agencies are likely to be beneficial.

29. A single, web-based multi-agency record for use in such rapid response investigations woud be ideal, to ensure all information entered is immediately available to all agencies. Such a format would facilitate the development of a specific "child death investigation" record as outlined above.

c) Previous experience of working or training together

1.Professionals from different agencies who have trained together will have a better understanding of the nature, role and requirements for information by each profession.

2. Individuals who have worked or trained together will have had the opportunity to develop co-ordinated approaches to

information collection and care of the family and the quality of service provided may thus be enhanced.

3. Lack of multi-agency training or experience may lead to heavy handed behaviour and lack of appropriate inter-professional communication by members of any of the relevant professions.

d) Suspicious or possibly suspicious circumstances

1. Even if history, demeanour or observations initially suggest the possibility of a non-natural cause or set of circumstances, it is important that all those involved retain an open mind and do not jump to conclusions at an early stage of the investigation.

2. There should be an early and continuing joint assessment by the attending police officer and paediatrician and a joint decision on the level of suspicion.

3. If there are significant suspicions about a possible crime it may be necessary to interview the parents separately and formally under the regulations of the Police and Criminal Evidence (P.A.C.E.) Act.

4. The presence of suspicion or possible suspicion should not change the nature, content or conduct of the interview but should emphasise the importance of very careful verbatim documentation of information as quickly as possible.

5. Inter-agency or inter-professional communication is of particular importance in those circumstances where there are suspicions of a non-natural cause but it is important not to over-react and to maintain good communication with the family at all times if possible.

e) Separate interviews of parents or carers?

1. Separating distressed and grieving parents may be very destructive and may lead to apparent discrepancies and

differences in perception or recall being recorded when these may merely represent different observations of the same event from a different perspective being reported at a time of extreme distress after the death of a child.

2. From the police and criminal evidence perspective, separate interviews may be of great importance if there is concern or a possibility that individuals are colluding in giving misleading or inaccurate information.

3. In many instances the parents are not both present at the time of initial history taking – thus the initial history will be taken only from the one parent who is present.

4. There may be indications that one or other parent is less likely to speak in the other's presence. Reasons for such indications may be medical, social or related to suspicions – interpretation and decisions on how to proceed in such circumstances must be made following careful multi-agency discussions.

5. Decisions on collecting separate histories from parents should whenever possible only be taken after close consultation between a senior police officer and a senior doctor.

6. Given the adverse effect this may have on the family, a decision to require parents to be interviewed separately should never be taken lightly and professionals making such a decision should carefully document the reasons for doing so. They may be required to justify it later, possibly to a court.

7. It is important that the parents are informed, if appropriate, about why a decision has been made to talk to them separately.

f) Detailed examination of the child

1. This is essential in all cases.

2. A careful and thorough examination should be carried out by a senior paediatrician or emergency department doctor as soon as possible and documented in a structured manner using body charts.

3. On occasions the examination – particularly of an older child or where there may be concerns about sexual activity or assault may be best conducted by a Forensic Medical Examiner or a paediatrician with special expertise in the examination of sexual assault victims.

4. Careful and early examination of the child is of great importance in identifying the position and distribution of livido (changes in distribution of skin colouration over the first few hours after death), the presence of any discolouration or other marks on the skin, the presence and distribution of any injuries, skin rashes or other abnormalities that are visible.

5. Livido is the progressive darkening in colour of the skin in the lower parts of the body, caused by the effects of gravity with progressive sedimentation of red blood cells. This is usually accompanied by pallor over any points of pressure - particularly when the body is resting on any firm or bony prominences – e.g. the hip, the shoulder, or the nose. Livido may appear very soon after death in young infants (begins to appear within 25-30 minutes), but is usually not "fixed" for at least 3-4 hours after death. Once the livido is "fixed" its distribution does not change when the body is moved to a different position. Prior to livido becoming "fixed" it will change such that, after a period of an hour or so it may be seen over the lower parts of the body in the new position rather than its original distribution at the time the body was found. Thus the appearance of livido as well as its distribution may change with time after death, particularly when the initial position in which the child was found is not the same as the position (virtually always supine) in which the body is placed in the mortuary or the resuscitation room. As noted above, in addition to the darkening of dependent areas of skin, there is commonly pallor of those areas of skin on which the body is resting – particularly those overlying bony prominences. For example, if an infant has been lying face down, there is commonly darkening of the face, including the forehead and nose, but there may be a small area of pallor overlying the tip of the nose, one of the cheek bones, and/or an area on the forehead. The development of these areas of pallor follows a similar time course to the development of livido, and also progressively becomes "fixed" over a similar time period. Thus careful documentation not only of the position and distribution of livido, but also the presence and position of any areas of pallor of the skin may be of great value in identifying or verifying the position in which the child was lying. The time taken for livido (and for pallor over pressure points) to develop is less well defined for older children, but is likely to be somewhat longer than for young infants. Because of the rapidity of such changes after the death of a child it is essential that all observations are accurately timed in the record.

6. In instances in which the initial distribution of livido suggests that the body was not supine for the period after death until being found this must be carefully documented, and if appropriate photographed (though photographs accurately showing the distribution and appearance of livido are technically difficult to achieve).

7. After fires or other specific forms of traumatic injury, it is of great importance that the child is examined early by a person with training and experience in assessing the likely significance of such observations. Such an examination may best be conducted as soon as possible after the event by a trauma surgeon or a consultant in accident and emergency medicine. As for livido, appearances may change in the few hours after death, so early examination may be particularly valuable in

elucidating the initial findings.

8. Generally the physical examination looking for medical problems should be by a paediatrician. Immediate assessment of the nature and possible significance of traumatic injury should be conducted by a doctor with appropriate training and expertise.

9. Assessment of the state of the child, e.g. nutrition, health, cleanliness should ideally be conducted jointly by a paediatrician and a police officer as soon as possible after death. Whenever concerns have been raised about neglect or abuse contributing to the death, this examination may be assisted by information from professionals (for example in children's social care or from the primary care team) who had knowledge of the child prior to death in order to identify recent changes.

10. Where a forensic postmortem is to be undertaken it is important to discuss and agree the nature, timing and extent of the physical examination of the child as soon as possible with the pathologist. A joint, early examination of the body by the paediatrician and pathologist may be helpful in interpreting observations made by both, but because of the shortage of both paediatric and forensic pathologists such a joint examination will rarely be possible. Interpretation of the transient changes seen in the immediate period after death in children (for example the changing appearance and distribution of livido) may not be within the expertise of a pathologist.

11. Whenever possible the paediatrician who examined the child after death should attend the postmortem examination, in order to help identify further changes in appearance that may have occurred since the initial examination. Unfortunately, because of the heavy workload of paediatricians, and the scarcity of paediatric pathologists, such attendances are likely to be uncommon in most areas of England.

12. Careful documentation is of crucial importance and, where appropriate or possible, photographic recording may help supplement the observations (bearing in mind that photographs often do not clearly show subtle differences in skin appearance that may be easily identified by naked eye examination).

13. It is important to recognise that a number of observations may change quite rapidly over the first few hours after death in young infants, including not only the distribution of livido but also the appearance of the effects of skin trauma (e.g., bruising). Unless there is very good communication between (and preferably a joint examination of the body by) the pathologist and paediatrician, misinterpretation of findings by one or both may occur.

g) The assessment of the likelihood of siblings or other children suffering harm

1. Parents must be asked about all other children, their health, well-being and whereabouts, including who is looking after them.

2. It is important that the needs of siblings are identified and prioritised early in the course of the investigation, and kept in mind at all times during the processes. Ensure that siblings are appropriately cared for, supported and informed of what is going on. Even young children will recognise and be distressed by the disruption that follows the death of a sibling, and distressed parents may have difficulty recognising and dealing with all of the needs of their surviving children. Families commonly need help and advice on how to support and care for surviving children.

3. Our overriding responsibility is to the safety, health and well-being of other children. Early joint discussion between police, health staff and social care should consider whether there are any medical risks (for example; infectious disease) or any possible concerns regarding maltreatment.

4. Whenever there is any concern about the possible need to take protective action regarding a child or children, a very careful multi-agency assessment led by children's social care should be conducted as quickly as possible.

5. Primary responsibility for the welfare of other children rests with children's social care, but all agencies share joint responsibility for ensuring careful and thorough assessment of potential risks of harm.

6. Concerns about children can arise for a number of reasons and even when parents may seem to have behaved inappropriately, children may not necessarily be helped by separation from their parents (on whom they are likely to rely very heavily for support) at a time of upset or trauma.

7. Separation from parents (even neglectful or abusive parents) may in itself be a traumatic and distressing experience for children – separation is never a "neutral" action. Whenever possible children should remain in the company of an adult they know and trust.

8. The over-riding factor influencing decisions about appropriate placement and care of any bereaved sibling must be the safety, welfare and best interests of the child.

9. Recognising that the needs of parents and children may be different, it is important not to over-estimate or over-emphasise the significance of perceived differences as being evidence of a risk of harm to the child.

3. Initial multi-agency or multi-professional processes, interactions and information exchange

a) Information sharing between professionals and agencies

1. All professionals involved in responding to unexpected deaths of children should be able legitimately to share relevant information with appropriate persons; legal and ethical restrictions, professional codes of conduct or other relevant guidance will not necessarily constitute an absolute barrier to the sharing of information, but there may be circumstances in which the exercise of judgement is needed.

2. Before sharing any information, the professional must be satisfied that it is appropriate to share the information in question with the intended recipient. It is important to know the purposes for any information exchange – who the information will be shared with, what information is required and why. Decisions on information sharing (i.e. what information is shared, with whom, and why) must be recorded in each agency's records.

3. All professionals need to know where to access information and advice on information sharing with their agency or from their Caldicott Guardian.

4. Government guidance on information sharing should be followed for siblings, parents and other family or household members. [http://www.everychildmatters.gov.uk/delivering services/informationsharing]

5. The guidance on information sharing and information protection issued under the Multi Agency Public Protection Arrangements (MAPPA) may also be helpful in establishing processes and protection for information sharing in child death investigations. [http://www.homs.justice.gov.uk/protecting-thepublic/supervision/mappa/]

6. Issues of possible professional culpability or of criminal acts require decisions about what information can be shared with whom and when. In particular, the police, Crown Prosecution Service and the coroner should be consulted when there are potential or ongoing criminal investigations, prosecutions or inquests.

7. Even where criminal prosecution is likely and information may have to be withheld from potential suspects or other family members, it is important that appropriate sharing of some information occurs between senior professionals in different agencies. This must include knowledge of the circumstances in which information is being withheld, thus avoiding other agencies making the mistake of assuming that a lack of receipt of new information means that no information is available.

8. Information sharing requires careful management because of the extremely sensitive nature and content of the information being shared. Careful measures must be put in place in all agencies to ensure protection of information about child deaths. The creation of a specific file in each agency to contain information collected as part of the child death response may be helpful. Such a file is already routinely created within the police service, and the creation of parallel files (ideally using a common template for content) within Children's Social care and Health would both facilitate information sharing and protection of sensitive third party information. In Health and Social care such a "child death " file could include copies of all relevant existing records at the time of the child's death, together with all additional information arising as part of the rapid response process.

Ensuring communication with appropriate professionals in all agencies

9. Good communication networks between and within agencies are of great importance and must be maintained at all levels.

10. Person-to-person communications work best – for example. meeting or using the telephone rather than just written communications. Written and spoken communications complement each other and the combination reduces the risk of misunderstandings.

11. All agencies should give a prompt response when contacted even if they have no new information to add – positive confirmation of a lack of new information may be very important in avoiding mistakes.

12. It is important to record what, when, and why, information has been shared in a one-to-one discussion with a member of another agency, and similarly if sharing has taken place in a more formal meeting between representatives of several agencies.

b) Ensuring good inter-professional information sharing without compromising specific needs of one agency (for example, police needs for evidential outcomes)

1. Nothing beats direct (preferably face-to-face) discussions, but in many circumstances this will be difficult to arrange, and delays in arranging meetings should not impair the conduct of an enquiry.

2. Prioritise the initial information sharing and planning meetings.

3. Agency leads should preferably be delegated to obtain relevant information from within their own agency – this tends to lead to more comprehensive information gathering than if sought by professionals from another agency.

4. Each agency should decide what information to share and with whom; agencies should be aware of each others policy and practice. It is important for agencies to understand the legislative basis for another agency's decisions. If specific information is not able to be shared at a particular point in time, this decision should be disclosed at the initial information sharing and planning meeting.

5. Consider communication between very senior members of each agency when on occasion detailed information is not able to be shared with those in immediate and continued contact with the family.

6. Sensitive information on third parties may cause difficulties if it does not appear to be relevant to an understanding of the case; professionals (particularly health professionals) may feel reluctant to share such information as to do so may appear to go against professional guidance. If such information is deemed to be relevant by the lead professionals then this information must be shared. If in doubt professionals should consult a senior manager or senior officer within their agency.

7. A consensus between agencies on what should be shared should be reached if possible, but it is important to record any dissenting views.

8. Where there is disagreement the relevant dissenting agency would have to decide what information to share with whom, but such a decision must be made at the highest possible level – junior staff should not be required to make such decisions about information sharing.

9. Full record keeping of decisions made is essential as well as of their rationale of information requested and obtained.

10. Incorporating provision for recording decisions about information sharing in a "death investigation" file (as suggested above) may be helpful.

Circumstances in which information sharing may commonly be limited between agencies

11. Impending or likely criminal prosecution.

12. Concern about health and safety of other members of the family or social group.

4. Site or scene visit

a) Who should attend?

1. Attendance at the site or scene of the death may be considered in two phases: immediate attendance (e.g. by first responders) and later attendance (as part of the rapid response process).

2. Decisions on who should attend the home or scene visit as part of the rapid response process should be made at the initial joint agency information sharing and planning meeting (which will most commonly be a combination of a meeting of those initially involved – e.g. police and paediatrician in the emergency department – together with telephone communication with other agencies – e.g. social care).

3. Timing of the visit – there is a potential tension between the need to visit as soon as possible to ensure no contamination of the scene or loss of evidence, and the need to ensure all the relevant background information has been collected in order to get as much as possible from the scene visit.

4. If the family or witnesses are not yet ready to revisit the scene you potentially lose the most important information source about what happened – often the interpretation of the significance of observations at the scene is only possible with information about the sequence of events and actions/roles of individuals that will come from a scene visit with someone who was there.

5. The home or scene visit is better done once, but effectively and a little later rather than done immediately, without family input and thus the risk of missing important information. This emphasises the importance of effective scene preservation before the visit.

6 Where there are obvious suspicions, it may be appropriate for the police to carry out the first scene visit alone (possibly accompanied by forensic investigators).

7 Police or Specialist Police Assessors (e.g. Road Traffic Collision Investigators) should attend the scene in almost all cases of unexpected death of children, except some of those deaths that occur in hospital, hospice or other healthcare settings. The decision as to whether it is appropriate or necessary for a police officer to attend must be made after direct discussion, involving healthcare professionals and police.

8. For non-trauma unexpected deaths in a home environment, a paediatrician (or specially trained children's nurse or health visitor) together with a police officer should carry out a home visit in most cases.

9. The question of whether there is a role for a paediatrician to attend in trauma-related deaths in the home must be reviewed in each individual case. Where knowledge of normal developmental abilities and activities of children of specific ages would be helpful, the paediatrician or health visitor may have a role in helping to understand the sequence of events – or in assessing the likelihood that such a sequence could have occurred.

10. Regardless of their perceived role in interpreting the sequence of events leading to death, the paediatrician and/or specially trained health visitor will almost always have a role in the home visit of supporting and providing information and care to the parents, siblings or other household members.

11. The question of whether a professional known to the family (e.g. GP, health visitor, midwife) should attend the home visit at the same time as the Rapid Response Team is controversial. In some circumstances the presence of a known and trusted professional who is able to provide support and care to the bereaved family as well as to help provide accurate information on relevant past history may be helpful, but in other circumstances – e.g. where the family may have some concerns about the adequacy of previous care or advice given to them by their primary care team – the presence of a member of that team may impair communication. There may also be circumstances in which concerns about child protection issues may be raised by the Rapid Response Team, and in such circumstances future communications with the primary care team may be compromised if they are perceived by the family to be part of that process. In these circumstances it may be better for the primary care team to visit the family as soon as possible after the Rapid Response Team visit rather than at the same time. It is clearly important that the primary healthcare team are informed as soon as possible of what has happened, and all possible information is obtained from them at the earliest opportunity, but the question of whether a member of the primary care team should attend with the Rapid Response Team is one that will need to be answered on the basis of a careful assessment of possible benefits or disadvantages on an individual basis. The continued care and support of the family – whether or not child protection issues have been raised – is an important part of the continuing role of the primary healthcare team, and they should be kept informed and encouraged to maintain close contact with the family.

12. Forensic investigator(s) may also need to attend either together with the paediatrician/police officer or prior to their visit (depending on the reported circumstances of the death). There is however some potential tension between the need to preserve and record the scene as it is, and the need to understand and record the dynamics of what has happened. There will potentially be great difficulty for the forensic

investigator in assessing the importance of various aspects of the death scene until the parents/carers have had the opportunity to go through this with the police officer and paediatrician or health visitor at the joint home visit. Decisions about the order in which such visits occur will need to be made on an individual basis, and for many non-suspicious deaths there will be no requirement for a visit by a forensic investigator.

13. For deaths outside the home, a team consisting of the most appropriate professionals (e.g. police officer, forensic investigator, paediatrician, social worker) should visit the scene, ideally with a parent/carer, or other direct witness to the event.

14. A paediatrician or appropriately trained health visitor or children's nurse should attend in all circumstances where knowledge of developmental attainments, likely abilities at different ages, physiological requirements for children and the possibility of organic illness are under consideration. As noted above, this may include not only unexpected deaths of infants or young children, but also some deaths from trauma in the home or other places.

15. Where deaths have arisen in circumstances suggestive of non-accidental injury or in which this possibility must be considered because of background history or previous events an appropriately trained social worker should always be consulted and should usually attend.

16. The specific training and experience of social workers in making assessments in homes and in multi-agency working are important skills which should not be under-estimated.

17. It is a cause of great concern that relatively few children's social care professionals have experience and involvement in the investigation of unexpected childhood deaths, and addressing this lack of training and experience should be a priority in planning future service provision.

b) Specific roles of each profession in the home or scene visit.

1. The primary role of the police is investigation - scene preservation and review; taking any photographic/video recordings and any measurements (usually carried out by Crime Scene Investigators); searching, securing and preserving forensic and other types of evidence, identifying witnesses and suspects.

2. Police also attend to identify any evidence suggestive of non-accidental injury, neglect or abuse, to identify inconsistencies between descriptions and observations and to identify possible environmental hazards that may have contributed to the child's death.

3. Healthcare professionals contribute experience and knowledge of the abilities and limitations of children of different ages: seeing the circumstances of death may prompt more appropriate and detailed questions of the nature and sequence of events leading to the death which may help in understanding the processes that have led to the death whether natural or unnatural.

4. The role of the paediatrician, health visitor or children's nurse is not to be a surrogate police officer but to take a detailed, careful and thorough medical, social and developmental history in the setting in which the child collapsed or died and in which environmental prompts, observations and facilitated recall by the parents or carers may allow a far more detailed description to be obtained than is the case with even the most sympathetic and sensitive professional in the emergency department.

5. Part of the role of the paediatrician (or more commonly the health visitor) is in providing information on the common socially and culturally determined variations in infant and child care practices within a particular community. What may be important is not "Is this what I would have done?", but "Is this a common practice in this social or cultural group?" It is important however to identify any practices which, although relatively common in a particular social or cultural group may be hazardous or undesirable. It is also important not to be seen to condone unsafe practices.

6. Healthcare professionals attending as part of the rapid response team are primarily healthcare professionals, and are thus bound by their professional duty of care to patients/clients with whom they have contact. They may thus have an important role in providing information, care and support to the family at the time of the rapid response team visit, regardless of their role in assisting the investigation of the cause of death. It is not the role of the healthcare professionals in the rapid

response team to take over continuing care and support for the family – this is the role of the primary healthcare team – but they must ensure that the primary care team are informed of any specific needs that they identify, and they must try to facilitate and encourage continuing care provision for the family by the primary care team.

7. Primary care or other professionals known to the family are important in providing general medical and bereavement support.

8. Children's social care professionals are skilled and experienced in assessing the nature and quality of family interactions and the suitability of home environments for children of various ages. They are also very skilled in inter-professional and inter-agency working as this is proportionately a larger part of their day to day activity than for either of the other two main professional groups. They may thus have an important facilitatory role in the conduct of site and scene visits, particularly visits to the home of a family of a child who has died.

Pre-planning of roles and agreement of roles and responsibilities between those attending home, site or scene visit

9. A thorough review and agreement about individual roles and responsibilities by the relevant professionals before the visit is important, but time rarely permits the development of such an agreement from scratch in the circumstances of a particular child's death. This emphasises the importance of prior joint training in order to provide an agreed framework upon which individual assessments and agreements can be based.

10. As far as possible there should be an agreed agenda for a home visit, so that each professional is aware of the particular aims and intentions and how it is hoped to achieve these – the precise agenda will vary from one instance to another.

11. Many of the questions and specific actions required at the time of the scene visit are generic, that is they are not dependent upon one particular set of professional skills. Thus mutual agreement before the visit on the division of these questions and actions between the relevant professionals may be helpful to avoid duplication and to ensure that all areas are covered.

12. The "medical" aspects of the history and review of circumstances should generally be led by the health professional but it is likely that social care professionals or police will have particular questions which may help to elucidate details of the information given.

c) Forensic considerations

1. The great majority of unexpected deaths of children are not the result of neglect, abuse or inappropriate care, but are natural tragedies. It is important that the need to identify the relatively uncommon cases in which neglect or abuse has occurred does not lead to victimisation, inappropriate treatment, lack of care, or perceived suspicion of families experiencing what is arguably the worst and most painful process anyone can experience – the death of their child.

2. Where there are significant suspicions, forensic considerations are second only in importance to the preservation of life or prevention of injury, but should never negate the family's needs for information, care, sympathy and support.

3. Forensic considerations are the responsibility of the senior attending police officer, in conjunction with a crime scene investigator or crime scene manager, and will be guided whenever possible by discussion with the paediatrician and other professionals involved.

4. All professionals undertaking home visits must understand the basic principles of forensic investigation and the need to avoid contaminating a scene which may subsequently be regarded as a crime scene.

5. It is however of great importance for all agencies to recognise that careful review with the parents or carers of the events that occurred within the environment in which it occurred may facilitate recall, may allow a more detailed description of the sequence of events and thus allow much better understanding of what has happened.

6. It is important also to recognise that some families may not wish to return to the place in which their child died, and for those who do wish to do so, the nature and timing of such a return may require considerable forethought by the professionals involved.

7. All professionals should be aware of the potential conflict between the need to preserve the scene and the need to allow the family to return, with help and support, to the place where their child has died and to talk through in detail what has happened. A realistic multi-agency assessment should be made at as early a stage in the process as possible of the relative importance of these two requirements.

Decisions on the relative importance (or reality) of forensic considerations and the balance between these and the needs of the bereaved family

8. A very careful review of all the information by the most senior professionals involved is important in order to make an assessment of the level of likelihood that a death has arisen as a consequence of neglect or abuse, and the potential

additional value to be obtained in understanding what happened by visiting the scene and carefully going through the sequence of events with the parents or carers.

9. The decision on when and if a home or scene visit is to take place must be made jointly by senior members of the agencies involved, and after careful review of all available information. Rapidly changing circumstances or urgent requirements to collect particular information may make joint discussion difficult, but unilateral decisions taken by any agency in isolation on scene protection or return to the scene with families should be avoided.

Home Visits subsequent to forensic investigation

10. Where an initial forensic assessment has been deemed appropriate and important, then subsequent return to the site by a multi-agency team with the parents or carers may help elucidate much of the additional information that can be gleaned from an immediate return to the scene. Although, inevitably many things will have been moved or disturbed and the immediacy of the parents' recollection would be less reliable.

d) Home Visits when a child has died elsewhere

1. This is sometimes very helpful in assessing family dynamics, getting information on the nature and conditions of the home background and to review in more detail the circumstances that may have preceded the sequence of events that led to the child dying.

2. Parents will usually feel more at ease in their own home, and thus be better able to give detailed information.

3. Professionals may be able to offer more appropriate and effective support having met and spoken to the family in their own home. Whilst it is important that health care professionals in the rapid response team recognise and understand the family's needs and immediately respond to them, it is also important to distinguish the role of the Rapid Response Team from that of the primary healthcare team who will continue to provide continuing care.

4. Such a visit will often be best conducted by a social worker jointly with a paediatrician and/or a police officer, sometimes accompanied by a professional (e.g. GP or health visitor) known to the family. It is important however not to overwhelm the family by the simultaneous attendance of too many professionals.

e) Videos and still photographs

1. The collection of video or still photographic information by a police officer or forensic investigator visiting the home as part of a multi-agency response is sometimes extremely valuable.

2. In this setting, video recording is particularly helpful as it may be possible for parents to directly demonstrate on the video various points that they have made in the earlier interview (e.g. in the Emergency Department). This is often helpful in clarifying potential ambiguities in the description of circumstances or series of events.

3. Still photographs are sometimes helpful but are much more difficult to use as a description of a sequence of events.

4. In general, still photographs require a much higher level of professional photographic expertise and where deemed to be helpful should usually be taken by expert police photographers.

f) Specific skills required for the conduct of home visits.

These skills are required by members of the team attending the home visit, but not all skills will be present in all members of the team – for those involved in such visits it is important to recognise which skills they do not have (and for which they will rely on other members of the team) as well as which skills they have (and which may not be possessed by other members of the Rapid Response Team).

1. Sensitivity and empathy with the family – i.e. an ability to listen (receive the information) and to hear what they are trying to say (interpret correctly).

2. History taking – narrative, medical and social - allowing parents/carers to give information in their own words and in their own order without missing any potentially relevant information.

3. Knowledge of conversational management techniques, and agreement about who will "lead" the discussion with the parents/carers – this may vary for different parts of the discussion.

4. Sensitive and responsive questioning; ability to guide the history to cover the important areas without "leading" the content.

5. Understanding child health and development, and the particular needs and abilities of children of different ages

6. Knowledge of cultural and behavioural norms within the particular social, religious or ethnic group involved.

7. Observation and accurate, impartial recording of the scene.

8. Interpreting findings – both history and observations.

9. Understanding what information is likely to be of value to the pathologist and/or the coroner.

10. Providing information to parents/families in understandable "accessible" language, but without breaching principles of joint agency communication.

Training needs.

11. These skills are best acquired by an "apprenticeship" model, perhaps using work-based tutors.

12. Some of the skills can be gained by training, including reviewing photographs/videos of scenes, role play. Some of this can be given in a classroom setting perhaps using role plays.

13. There is a need to develop work based assessments against certain competencies, perhaps building to a practical qualification for those involved in this work.

Specific investigations/measurements.

14. The SUDI protocol recommends the recording of room temperature, ideally taken deep within a pile of clothes in a drawer in the room in which an infant has died unexpectedly (as this temperature may remain stable for some time after the baby's death). *(Reference: Sudden Unexpected Death in infancy: a multi-agency protocol for care and investigation 2004 [http://www.rcpath.org/index.asp?PageID=455]).*

15. The protocol also recommends the routine recording of north-south orientation in order to attempt to ascertain whether conditions might have been different at the time of death (e.g. sunlight coming through windows).

16. Routine measurement of the size of a room and a sketch plan drawing of the layout of furniture and position of people is often helpful also.

17. The above information is probably most reliably recorded by the police.

g). Indications or observations at the home visit that raise the possibility of non-natural causes of death.

NB. None of these observations is sufficient on its own or in combination with any other factor to suggest that a death is not natural, but the presence of one or more of these factors should raise investigators awareness of this possibility. Families in which these factors are present are also at increased risk of natural causes of childhood death – perhaps related to lifestyle risk factors, so it is important not to over-react or to (possibly inadvertently) deny such families appropriate help and support.

1. Extreme levels of squalor (e.g. lack of cleaning, unwashed clothes and dishes, rotting food, any excrement – human or pet).

2. Evidence of uncontrolled substance abuse (e.g. needles or other drug paraphernalia).

3. Evidence of excessive alcohol consumption.

4. Evidence of mental health problems involving the parents, children, carers, other family or household members.

5. Parents or carers with significant learning disabilities – this may require special arrangements to ensure the parents understand what is happening and the purpose of the investigation. It is important not to misinterpret actions or communications by people with significant learning disabilities.

6. Dangerous sleeping environments.

7. Evidence of trauma (e.g. frank blood stains or blood spattering).

8. Significant inconsistencies in the history or descriptions given. Commonly there may be minor variations in the history as given in the Emergency Department compared with that given in the home. Part of this may be due to environmental triggers to memory – the parents commonly recall much more clearly what happened when surrounded by the objects that were there at the time of the events being described – objects, smells, sounds and appearances may trigger recall of details not remembered when being asked in the Emergency Department.

9. Findings (e.g. observations by the rapid response team members, or details within the history) that do not match the previously elicited history or examination findings – as noted above, minor apparent differences are common – and may reflect either limited recall away from the home or limited linguistic ability of the parents to clearly and unambiguously describe events –major discrepancies are much less common, and need careful review.

10. Inappropriate, aggressive or unexpectedly uncooperative behaviour from those present – including other members of the household or visitors.

11. Inappropriate or insufficient toys, infant food, bedding etc.

12. Writings, diaries, computers etc which may provide an insight into the thoughts of the deceased, siblings and other significant people.

13. Any such indicators should be discussed by the police officer and paediatrician, and may require the police to take a more direct lead.

14. Remember to listen to what the siblings have to say – both in general and whenever possible and appropriate – concerning the death of their sibling.

If significant concerns arise then further investigations (led by the police) may include:

15. Consider reviewing home videos, photographs etc. for evidence of appropriate handling of the child.

16. Examine calendars and diaries for critical events, evidence of bills or other stresses.

17. Look for items which may have caused induced illness e.g. salt, drug, insulin.

18. Consider evidence of the 'trigger' or motive – e.g. dirty nappy, partially consumed baby bottle, vomit, splattered food, items of equipment for special needs babies.

19. Consider obtaining copies or if necessary seizing any records to show developmental level or difficulties with the child e.g. parent-held child health record.

20. Consider telephone records / enquiries to assist in identifying timings, witnesses etc.

21. Consider collecting information from other local sources including friends, neighbours etc.

h) Indication from any aspect of how other family members (eg siblings or extended family) or other household members behave, act or appear that raise the possibility of a non-natural cause of death

1. Allegations of possible harm from family members, friends or neighbours.

2. Siblings who appear abused/neglected, inappropriately unresponsive or withdrawn, or inappropriately attentive to visiting professionals.

3. Apparent significant differences between levels or standards of care between siblings – particularly when there are complex family structures with stepchildren and/or half siblings.

5. Further multi-agency exchange

a) The role and content of de-briefing

1. Full debriefing and mutual information exchange between all professionals involved in the investigation should occur as soon as possible after the home or site visit (a "hot debrief").

2. The debrief will help to ensure all observations and information have been captured and recorded. Observations made by one professional (e.g. police officer) may be more easily interpreted by another professional (e.g. health professional) - or vice versa.

3. As for the conduct of the home visit, there is a need for leadership and guidance in the conduct of debriefing. It is helpful if this is agreed beforehand.

4. All involved professionals have shared a difficult and upsetting experience and it is useful to recognise that and may be therapeutic to talk it through, though not everyone involved will wish to do so in this setting.

5. It is important also to consider the need for the provision of separate debriefing opportunities and professional support facilities for all members of the rapid response team to help deal with their responses to the commonly distressing nature of what they have seen and heard.

6. There is a tendency in some circumstances for professionals who have been involved in the care of a family in which a child has died unexpectedly to feel very vulnerable, and sometimes to view the detailed subsequent investigation as an attempt to "find fault" with their practice or professional management of the case. Given the extreme sensitivity in all professionals that has arisen from widespread media coverage of tragedies such as the "Baby P" case (2008), it is important to ensure that all professionals directly involved in the care of children who subsequently die unexpectedly are also given appropriate professional support, and are encouraged to fully participate in the investigation process.

7. There will be considerable shared learning for all agencies involved. Gaining insight into how other professionals respond to such experiences will help improve mutual understanding for future joint working.

b) Information sharing arrangements and how to record this

1. Follow Government Guidance on Information Sharing 2008 [http://www.everychildmatters.gov.uk/deliveringservices/informationsharing].

2. Information shared, objectives, decisions reached and rationale should all be recorded – ideally using a standardised information record or booklet (see section 2.b.1 & 2.b.29 above, and section 5.c.4 below).

c) Identification of key information

1. Senior professionals in each agency should identify points they consider to be of particular importance in the history or observations and share these with the other agencies. It is important to recognise that the identification of "key" information is extremely difficult early in the process, and continued review of new information is important, as the importance of previously collected information may change in the light of new (possibly apparently innocuous) information.

2. Booklets (not proformas) either hard copy, electronic or both which provide space to record the whole processes have been found to be particularly useful by many professionals. Such a document should be equipped with aide memoires and follow a potential chronology to assist both the process and those undertaking it. Furthermore this approach will provide some necessary consistency of approach whilst still allowing for innovation and adaptation as relevant to the circumstances presented. The steering committee reviewed a large number of such documents from many areas of England, and identified very many examples of excellent documentation and clarity of presentation of required information. The multi-agency documents produced for this purpose in West Mercia, Lancashire and Avon and Somerset are particularly to be commended.

Copies of these documents are available on the DCSF "Every Child Matters" website [http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/workingtogether/workingtogethertosafeguardchildren/]

3. A copy of the relevant completed sections of such a document would facilitate consistent communication if used as the standard format for informing the pathologist before the post mortem examination, the coroner or other appropriately interested parties as relevant.

4. As noted in section 2.b.29 above, the provision of a web-based common record will facilitate immediate information sharing and potentially improve interprofessional communication.

d) Informing the coroner

1. Initial responsibility rests with all professionals involved – but it is probably best if police (who will commonly initially be carrying the responsibility of acting as the coroner's officer) take responsibility for ensuring initial liaison with the coroner's office.

2. The lead professional in each agency is responsible for providing a report to the coroner.

3. The initial reports to the coroner will be important to the pathologist in identifying any specific questions that need to be answered, and will thus potentially affect the conduct of the postmortem – or the nature and extent of specific investigations that are required. The initial reports to the coroner should thus be as detailed as possible, including not only the history and observations of the relevant professionals, but also the interpretation of these findings from the multi-agency discussions that have taken place.

4. As far as possible the pathologist should not be expected to commence the postmortem examination without detailed initial reports from each professional agency involved.

5. If a single format of information documentation is used as suggested above this could be used as basis for report to the coroner. A web based system would ensure that the pathologist had access to the most up to date information from all aspects of the investigation.

e) Leadership and overall responsibility for the rapid response process

1. In most non-suspicious cases the lead will be the senior health professional involved, but in cases where there are major suspicions about non-natural causes, or concerns re child protection issues it may be a police officer or local authority social worker.

2. In many cases different professionals will lead for different aspects of the process, but agreement on who does what, and consistency in application of principles during the investigation are important.

3. The overall lead professional should be someone with

seniority proportionate to the level of responsibility for leading such a process. For example, in the police a detective inspector, in health a consultant or senior nurse of equivalent status, in social care a service manager.

4. In some police forces there is no guaranteed availability of officers from the Child Abuse Investigation team at all times. The police officer in overall charge of the initial police response may thus not be routinely involved in undertaking rapid response investigations after child deaths, but must ensure that procedures and police responses are in line with currently agreed local approaches rather than "playing safe" by heavy handed responses or working in isolation from the other relevant agencies.

5. Whilst specially trained health visitors or children's nurses are important members of the rapid response team, few will yet have sufficient seniority or experience to lead the multi-agency process. Given the fact that the great majority of unexpected child deaths are not suspicious, and many are related to underlying, previously unrecognised medical conditions, involvement of someone with an extensive and detailed knowledge of paediatrics is very important in the investigative process. There is thus a need for all nurses or health visitors involved as part of the Rapid Response Team to have immediate and continued access to a consultant paediatrician to help interpret the findings, to help with the diagnostic process, and to provide additional knowledge and information as required. It is also important however that the consultant paediatrician providing such support and back-up to a health visitor or children's nurse has some experience of working in the home and is aware of the potential significance of findings within the home environment.

6. Further investigations

a) Maintenance of effective information sharing during prolonged further investigations – medical, social and forensic

1. The designated doctor for child deaths should assume overall responsibility for ensuring this happens, but will commonly delegate responsibility for individual cases to the most appropriate "lead" professional (who may be from any of the relevant agencies).

2. There is a need within each investigation for a strong lead with the time and commitment to drive and manage the process in conjunction with named representatives from each of the relevant agencies. Often there will be little need to meet and updates can be managed by telephone or e-mail.

b) Keeping the family informed during the period of further investigations – and decisions about sharing information with family.

1. An identified point of contact or key worker should be responsible for communication with the family and should liaise with the overall lead to ensure all relevant information is passed to the family and to those responsible for providing their continued care – most importantly the primary healthcare team.

2. In many areas a Family Liaison Officer will be appointed (a police officer with designated responsibility to work with the family – predominantly as an investigator, but also to keep the family updated and to provide support) and may take on an important role in this process.

3. In other circumstances or other areas a Family Contact Officer will be appointed predominantly to ensure communication with the family rather than as an investigator.

4. When new or additional "medical" information becomes available (e.g. from a postmortem or investigations initiated in an emergency department), it is important whenever possible that this information be given to the family by someone with sufficient medical knowledge to be able to interpret the potential significance of the findings, in the light of the past medical history, the presentation and other possible relevant information. In practice this will almost always be the paediatrician or the family's general practitioner. It is of great importance that the provision of such information to families is prompt, but agreed by the members of the rapid response team, who must all also be made aware of its possible significance. Similarly it is important that when new potentially significant information, that may be of forensic significance becomes available, it is passed to the family by the member of the rapid response team most knowledgeable in the relevant field, but only after multi-agency agreement that it is appropriate to do so.

7. Local case review meeting at the end of the investigation

This meeting should be held, even if other processes including child protection enquiries or family court or criminal proceedings are ongoing, though the timing of the meeting will need to be agreed by all agencies. When child protection enquiries or family court or criminal proceedings are being considered or are ongoing there may need to be some restriction of the information available to the local case review. However the opportunity provided by the local case review for information sharing and planning of future care for the family and others affected by the death is important and only in exceptional circumstances should this meeting not be held.

a) Responsibility for organising this meeting

1. Should rest with the administrator of the local rapid response team, under the supervision of the designated paediatrician for unexpected child deaths (appointed by the LSCB).

2. Timing of the meeting will be determined by the "lead" professional involved – who may be from police, social care or health – and should be decided as early as possible in the investigation.

3. In order to facilitate attendance of the primary healthcare team, meetings are often best held at lunch time in the local health centre, but sufficient time must be allocated to ensure an adequate discussion. For most such meetings one hour is sufficient provided there has been adequate preparation and organisation of information by the chair and participants.

4. The organisation of this meeting may be difficult – co-ordinating diaries of several busy professionals – and may take a lot of time, so arrangements should be started as soon after the death as possible. On-line meeting scheduling tools (e.g. "Doodle" http://www.doodle.com/main.html) may reduce the work involved and facilitate the arrangement of meetings.

5. Once the date and time of the meeting have been agreed, it is important that all participants prioritise attendance at it – even if this means cancelling or rescheduling other appointments or commitments.

6. Because of the extreme shortage of paediatric pathologists it is unlikely that the pathologist will be able to attend many such meetings, but, in view of the high importance that is attached to the information provided by the pathologist in many cases, and the importance of being able to discuss possible interpretations of pathology findings, it is important to consider having the pathologist attend by telephone (or possibly video) conference call.

b) Who should attend

1. At least one senior responsible professional from each of the agencies involved.

2. All professionals involved in the response to the death plus any other relevant professionals holding information on the child.

3. The coroner or coroner's officer should be encouraged to also attend, as information provided at this meeting may be of value in helping to plan the inquest by identifying any important issues that may require dealing with at the inquest, and identifying which professionals should be called to give evidence. Many coroners will admit the report from this meeting as written evidence at the inquest, thus removing the necessity for attendance by some of the professionals.

4. Attendance at local case review meetings should be accorded a high priority by all involved. Cancellation or rescheduling of other commitments by key professionals may be required to ensure their attendance.

5. Relevant professionals who cannot attend should send a full written report on their involvement to the chair before the meeting or should ensure the attendance of a fully briefed deputy.

6. The meeting should be chaired by the designated paediatrician for child deaths or an agreed deputy.

7. Parents are not invited to attend such meetings, as the nature of the discussion – which may involve detailed presentation of pathology findings as well as questions about the quality of care provided by professionals, parents or others – will either be inhibited by parents' presence or will be unpleasant and potentially extremely distressing for them. For many such local case discussion meetings the child would have been living with a single parent, commonly very young.

Thus attendance at such a meeting with up to 10 highly articulate professionals potentially discussing minute details of the child's postmortem examination is not likely to be an empowering experience, and is likely to be extremely distressing for the parents. It is important however that the outcome of the meeting is conveyed to the parents in person as soon as possible afterwards, ideally the same day.

c) Recording the discussion and outcome of the local case review meeting

1. This is the responsibility of the chair of the meeting.

2. If resources permit then the attendance of someone not directly involved with the case, with a specific remit to take minutes/notes of the discussion may be helpful, but because of limited resources this will rarely be possible.

3. It is important to document all aspects of the history, examination and investigations in understandable language (minimise or eliminate all jargon – from any professional agency).

4. Document all findings in standard format – e.g. using the DCSF analysis proforma (i.e. "Form C") [http://www.everychildmatters.gov.uk/resources-and-practice/TP00045/].

5. For sudden unexpected deaths of infants (SUDI) the use of the Avon Clinicopathological classification, will give valuable insights into the relative contributions of different factors to the death perceived by those attending the case review meeting. This information may have important implications for future care and support of the family – similar classification may also be helpful in some other unexplained deaths for which contributory factors may be identified.

[Sudden unexpected death in infancy: a multi-agency protocol for care and investigation. 2004. [http://www.rcpath.org/index.asp?PageID=455]

6. A typed report from this meeting should be sent to all contributing professionals for confirmation, to allow distribution of a final report within 2 weeks of the meeting.

7. A written report from this meeting should be sent to the coroner and to each contributing agency within 2 weeks.

d) When the local case review meeting should be held

1. As soon as possible once all investigations (notably pathology, police and social care) have been completed.

2. The local case review meeting should precede (and thus help inform) the Inquest (see section 6.b.3 above).

3. The meeting may be delayed by criminal or family court proceedings, but may also go ahead, accepting that not all information will be available to those attending. In some circumstances the outcome of the local case review meeting is important in providing valuable additional information to inform and assist court proceedings – or sometimes to help inform the decision as to whether court proceedings should be initiated.

4. The meeting may be delayed (see above) by court proceedings or by a serious case review. In some circumstances both processes may be going ahead in parallel, and the outcome of the local case review meeting may help inform the serious case review.

8. Feedback to the family and other relevant agencies

a) Responsibility for feeding back the results of investigations and/or local case review meeting to the family

1. This responsibility rests with the chair of the local case review meeting – it is important to agree at the meeting who should pass information to the family. This will involve a lead professional from one or more agency, together if possible with a local professional (e.g. GP or health visitor) known to the family and with continuing care responsibilities to them.

2. It is important that this information is fed back as soon as possible – with the agreement of those attending the meeting. This will commonly be before the final typed report is produced. As the family will usually be aware of the fact (and commonly the date) of the local case review, it is important that they are not kept waiting for information following the review. Commonly it should be possible for the meeting with the family to take place immediately after the local case review (on the same day).

3. When the outcome of the local case review contains information that may be considered to be critical of parents, carers or professionals, it is important that the meeting gives careful thought to and agrees a format for the transmission of this information to the family. In these circumstances the information provided should take account of information being provided to the parents through any other related processes, such as root cause analyses or internal NHS disciplinery processes.

4. It is also important that, whenever necessary, arrangements are made for the family to have the opportunity to meet again with the relevant professionals to help answer questions that may have arisen from this initial meeting after the local case review.

b) Offering further support and information to the family

5. This is the primary responsibility of the local healthcare professionals – e.g. GP and/or Health Visitor, but further information and support should be available to them when required from an appropriate senior professional in each involved agency.

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