



Why Jason Died

A drama reflecting the multi-agency response to the unexpected death of a child to show new procedures and guidelines as outlined in Chapter 7 of *Working Together to Safeguard Children* (2006).

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Contents

The 999 call	4
Support and investigations	7
Multi-agency rapid response	10
Postmortem	13
Joint home visit	16
Devil in the detail	19
Outcome	22

The 999 call

Q1 What is an ‘unexpected child death’?

A1 An unexpected child death is defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse precipitating the events which led to the death – see paragraph 7.6 in *Working Together to Safeguard Children* (2006).

Q2 What does SUDI stand for?

A2 Sudden Unexpected Death in Infancy - the sudden death of an infant which was not anticipated by any professionals or carers involved with the child 24 hours prior to the event that led to the death.

Q3 Does this mean that, because these deaths are sudden and unexpected, they are suspicious?

A3 No, far from it. The huge majority of sudden and unexpected deaths in infancy occur as a result of natural causes and are an unavoidable tragedy for any family. Nevertheless, some sudden unexpected deaths do occur as the result of non-accidental injury, abuse or neglect.

Q4 When and where do sudden and unexpected deaths in infancy occur as a rule?

A4 Most of these deaths occur at home – at night or in the early hours of the morning. The family may telephone the GP or, more commonly, call an ambulance leading to the admission of the child to an A and E department.

Q5 What part do paramedics play?

A5 Paramedics play a vital role – not only because they are trained in infant resuscitation but because they are first on the scene, observe it carefully and make notes which they pass on to the paediatrician at the hospital.

Q6 What does SIDS stand for?

A6 Sudden Infant Death Syndrome – the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including an autopsy, examination of the death scene and review of the clinical history.

Q7 What are the factors that put an infant or child at risk?

A7 They fall into three main categories: factors intrinsic to the child (eg. congenital anomalies, low birthweight, poor growth); parental factors (eg. low maternal age, maternal smoking during pregnancy, family history of SUDI); environmental factors (eg. low income, unsupported mother, smoking in the house).

Q8 What does LSCB stand for?

A8 Local Safeguarding Children Board

Q9 Who are the members of an LSCB?

A9 The core membership of an LSCB, set out in the Children Act 2004, includes local authority services (eg. children’s social care, education, housing), health bodies, police, probation service, voluntary bodies (eg. NSPCC, Barnados) and others.

Q10 What are the overall objectives of an LSCB?

A10 The objectives of LSCBs are to co-ordinate local work to safeguard and promote the welfare of children and to ensure the effectiveness of that work.

Q11 Is there any difference between the new LSCBs and the old ACPCs?

A11 LSCBs have a wider range of responsibilities than the old ACPCs, taking a proactive role in respect of safeguarding issues for all children across the LA area. Specifically it has responsibility for collecting and analysing information on the deaths of all children in the LA.

Q12 How often does an LSCB meet?

A12 On average, three or four times a year.

Q13 What is the LSCB's role and function following an unexpected child death?

A13 From 1 April 2008 each LSCB must have in place the processes and procedures relating to unexpected child death set out in Chapter 7 of *Working Together to Safeguard Children* (2006). They become a statutory requirement by that date but can be carried out by any LSCB before then.

Q14 What are the new processes and procedures?

A14 The LSCB has responsibility for reviewing the deaths of all children resident in its geographical area, the setting up of a rapid response team following an unexpected child death, and the establishing of a Child Death Overview Panel. The LSCB is also responsible for undertaking Serious Case Reviews when appropriate.



Q15 What happens if a child dies in an area where he or she is not normally resident?

A15 The designated professional to whom the death notification is sent should inform their opposite number in the area where the child normally resides.

Q16 What is a rapid response team?

A16 A multi-agency rapid response team is the group of professionals who come together in response to the unexpected death of a child. They will work together to provide on-going care and support to the bereaved family; to collect information in a standard manner; to ensure that all investigations that may help to understand and explain the death are carried out sensitively and to a high standard.

Q17 Who are the members of a rapid response team?

A17 A team will include all those who are or will be involved with the child following his or her unexpected death ie: paediatricians, A and E hospital staff, members of the police child abuse investigation unit, GPs, health visitors, nurses, social workers and other professionals. It is vital that, from the beginning, all the agencies share information and work together in a co-ordinated, effective manner.

Q18 Who would the other professionals be?

A18 It depends upon the age of the child and the circumstances. If it is a new-born infant, a midwife might be involved. If there are parental mental health problems, an adult psychiatrist or CPN is likely to hold very relevant information. With an older child, there might be more agencies involved including teachers and education professionals, drugs workers, YOTs staff.

Q19 How does a rapid response team work? Especially in the middle of the night or the early hours of the morning?

A19 There is an on-call rota of all the professionals who might be involved in responding to unexpected child deaths in the area (healthcare professionals, children's social workers, midwives etc.). This is co-ordinated usually by the local designated paediatrician responsible for unexpected deaths in childhood.

Q20 What are the key principles that a rapid response team should adhere to?

A20 It is imperative that there is a sensitive balance between the care and support of the family and gaining an understanding of the cause of death. There should be a balanced, open-minded approach by all the agencies and effective sharing of information.

Q21 When the infant or child has been admitted to the A and E department at the hospital and attempts at resuscitation have failed, who looks after the bereaved parents?

A21 Where an infant or child has died in, or been taken to a hospital, their parents should be allocated a member of the hospital staff (support nurse) to remain with them and to support them throughout the process.

Q22 And what is the role of the police in the very early stages when no-one knows what has caused the death and whether or not it might be suspicious?

A22 In the initial stages it is important for the police to secure the scene of death, in a discreet and sensitive manner, so that no-one can go in or out and nothing is disturbed before the home visit, which will be arranged as soon as possible.

Support and investigations



Q1 Who tells the parents that their child has died?

A1 When the child has been pronounced dead, the consultant clinician (usually the consultant paediatrician on call) should break the news to the parents, having first reviewed all the available information. The interview should be in the privacy of a quiet, appropriate room. If English is not the parents' first language, arrangements should be made for an interpreter to be involved.

Q2 When a parent loses a child suddenly and unexpectedly, what are the usual reactions?

A2 There are no 'usual' reactions – parents in the early stages of grief react in many, and often surprising, ways. There is no set pattern. Reactions include disbelief, shock, numbness, anger, hysteria, rage.

Q3 What are the best ways for the support nurse and other hospital staff to deal with the different expressions of grief?

A3 The important thing is to provide support, empathy and a caring environment to the bereaved parents and any other family members who are at the hospital – no matter what the circumstances of the death. Give them time and space. Do not attempt to control these reactions in any way.

Q4 What is the difference between empathy and sympathy?

A4 Sympathy, while it has its place, is comparatively easy to offer – it is just words. Empathy, on the other hand, is much more about being with the person in that particular moment, however difficult it is. It is being emotionally aware and going through the profound grief with them. It might be holding their hand, it might be just being quiet with them.

Q5 What about if there was any suspicion that the death might have been due to neglect or abuse?

A5 In these circumstances, the bereaved parent also has very immediate and considerable human needs for support and care. In addition, there may be other members of the family, who were not involved in the death, and they will need significant help and support.

Q6 Following the first traumatic hours after the death of the child, when the necessary processes and procedures have been completed at the hospital, how is the care and support of the bereaved parents continued?

A6 It is important that the parents are offered the continuing support of one of the key workers on the case when they leave the hospital and go home. They should be given written contact names and telephone numbers. The key worker will be a constant point of contact during the next weeks and months and will be an emotional support. Ideally, the parents should choose their own key worker, depending on the circumstances and with whom they feel most comfortable.

Q7 When there has been an unexpected death, what is the Coroner's role?

A7 All cases of unexpected deaths in childhood have to be referred to the local Coroner immediately, and the subsequent assessment and management of the case will be carried out in close liaison with him or her. The Coroner has jurisdiction over the body and all that pertains to it.

Q8 Does the hospital have to get permission from the Coroner to carry out tests on the body and to take samples?

A8 Ideally, the hospital should have an understanding with the local Coroner that certain vital investigative tests can be carried out and samples taken in the hours after the death. If this is not possible, crucial evidence can be lost for ever. These routine procedures include taking a blood sample, urine sample, a skin biopsy, a lumbar puncture and a full skeletal X ray.

Q9 Are the parents informed about these procedures?

A9 Yes, the parents are told exactly what is happening to their child at all times. The consultant clinician or support nurse will explain why the samples have to be taken so quickly and what will happen to them. It is vital that parents are kept informed at all times. They should be allowed time to ask questions about practical issues. This includes telling them where their child will be taken and when they are likely to be able to see him or her again.

Q10 Do all members of the rapid response team come to the hospital?

A10 It is important that the appropriate members of the Police Child Abuse Investigation Unit (plain clothes) arrive as soon as possible to liaise with the consultant clinician for the child and to begin to find out what has happened. Even when there is absolutely no question of a suspicious death or criminal activity, the police will often be acting on behalf of the Coroner in collecting information and investigating the case.

Q11 What about other members of the team?

A11 Other members of the team (eg. GP, midwife, health visitor, social workers) may come to the hospital but, as time is of the essence, they often provide essential, initial, background information over the telephone in preparation for the strategy meeting which will be held as soon as possible in order to plan the home visit.

Q12 What about other agencies which might have been involved with the child?

A12 For all unexpected deaths of children (including those not seen in A and E) urgent contact should be made with other agencies who know or were involved with the child (school, voluntary groups, Youth Offending Team etc.) to inform them of the child's death and to obtain information on the history of the child, the family and other members of the household. The older the child, the greater number of agencies that are likely to be involved with the child.

Q13 Why is it important to collect so much different information about the case?

A13 It is vital to build up as complete a picture as possible right from the very start so that no clues are missed. Sharing information from different professional backgrounds is enormously helpful in understanding what might have happened, what might have contributed to the death.

Multi-agency rapid response

Q1 How do the different members of the LSCB learn about the new processes and procedures that must be in place by April 2008?

A1 All LSCBs should ensure that appropriate single and inter-agency training is available to explain and clarify the new processes and procedures and to ensure their successful implementation.

Q2 How is the new learning about child death reviewing processes disseminated from the LSCB?

A2 In each partner agency of the LSCB, a senior person with relevant expertise should be identified as having responsibility for advising on the implementation of the local procedures on responding to child deaths within their agency.

Q3 After there has been an unexpected child death and resuscitation in hospital has failed, are the bereaved parents allowed to see their dead child?

A3 Yes, it is extremely important that the bereaved parents are allowed to see their child after his or her death – with the support of the nurse who has been assigned to them or another professional. They should be given as much time and space as they need. Any IV cannulae, ET tubes and other equipment must be removed first.

Q4 Are they allowed to hold their child?

A4 It is normal and appropriate for parents to want physical contact with their child. In all but the most exceptional circumstances, such as when crucial forensic evidence may be lost, they should be allowed to hold their child for as long as they need to – with the support and care of the support nurse or other professional.

Q5 What is the role of the support nurse here?

A5 It is very important for the support nurse to be there for the bereaved parents and to share the moment with them – if appropriate. Perhaps to say how beautiful the child is, what lovely hair, the look of tranquillity on the face. This helps the emotional needs of the parents in the traumatic early stages of grief and helps them to move on.



Q6 Are the parents allowed to take a memento or keepsake of their child at the hospital?

A6 Yes. Parents often ask for a lock of hair or a hand or foot print, which would be taken for them by the nurse or paediatrician. Sometimes they ask for a photograph or an item of clothing.

Q7 Isn't it extremely difficult to start an investigation into what has happened at such a delicate time?

A7 The balance between sensitive investigation and support for the family are what the new processes and procedures are all about. It is important to gather as much information as possible from the bereaved parents themselves as soon as possible. The healthcare professional (usually a paediatrician) and the detectives from the Child Abuse Investigation Unit will take care of this together and interview the parents in a quiet place where they won't be disturbed.

Q8 Isn't that the last thing that bereaved parents would need? A police officer asking them questions at the worst moment any parent can imagine?

A8 Detectives in the Child Abuse Investigation Unit are all highly skilled in sensitive and intelligent questioning. Not only are they trained as detectives in the first place, they also go on the specialist Child Abuse Investigators Development Programme that has been rolled out nationally over the last two years. They are, of course, in plain clothes.

Q9 What kinds of questions will the parents be asked?

A9 They will be asked about the circumstances that led up to the death, the child's health, the pregnancy (if the baby is new born), where the child was sleeping, family history, information about siblings, smoking in the house etc. Everything will be carefully noted down to be added to the other information that has already been collected from the paramedics and the other agencies involved.

Q10 Who takes the lead in this?

A10 It is a shared approach using all the particular skills and expertise of the paediatrician and the detectives of the Child Abuse Investigation Unit. The healthcare professional (usually a paediatrician), of course, has a wide knowledge of child health, development, illnesses etc. and the police are highly experienced in criminal investigations.

Q11 It must be very difficult for the parents to remember exactly what happened when they have been through such a trauma.

A11 Indeed. Questions often have to be repeated and it is extremely important to be patient and calm. But sometimes, because parents are still in shock, it is almost a relief and a comfort for them to go through what happened and to share it.

Q12 Will the parents be questioned again?

A12 They will go through things again at the home visit, when they return to the scene of death with the healthcare professional (usually a paediatrician) and the detectives from the Child Abuse Investigation Unit.

Q13 The actual balance between support and investigation can be quite difficult, can't it?

A13 The balance can be very difficult because, as long as the death is unexplained, there is a possibility that it was due to an unlawful act. What is vital, as the different pieces of information are being put together, is to keep an open mind and not to jump conclusions.

Q14 How do the parents cope with this? That they might be under suspicion?

A14 In the vast majority of cases, an unexpected death is due to natural causes and the parents want, above all, to find out why their child died. For this reason, although it is difficult, they understand that the more information they give, the more likely it is that an answer will be found.

Q15 Who asks for a postmortem to be carried out?

A15 The local Coroner, who has jurisdiction over the body, and is responsible for managing the investigation into the death.

Q16 When is this carried out? And who does it?

A16 It is recommended that a postmortem examination is done as soon as possible. In the case of an infant or child death, it is performed by the most appropriate pathologist available (this may be a paediatric pathologist, forensic pathologist or both) – see paragraph 7.39 of *Working Together*.

Postmortem

Q1 Who tells the parents that there must be a postmortem?

A1 The consultant clinician (usually a paediatrician) should tell the parents that the Coroner has ordered a postmortem examination and that this is a legal requirement. The paediatrician should also explain the authority and involvement of the Coroner and the Coroner's Officers in the investigation.

Q2 What is the role of the Coroner exactly?

A2 The Coroner has jurisdiction over the body and his or her role is to find the cause of death. The Coroner must always be informed of the death immediately.

Q3 Do the parents have any right to object?

A3 No, if a Coroner orders a Postmortem, then it is a legal requirement for it to be carried out. It is important to explain sensitively and clearly what is involved. Do not ask permission.

Q4 Isn't this very difficult to do – when the parents are in the first traumatic stages of their grief?

A4 It is difficult but it is the duty of the paediatrician to explain the importance of the postmortem examination. All parents want to know why their child died and the postmortem is the means of identifying the cause of death. As long as this is explained, parents usually accept it. They want to know whether or not the death was preventable, whether or not it was genetic and so might reoccur in future pregnancies.

Q5 Are the parents told exactly what a postmortem involves?

A5 Yes, it is very important that the parents are told, face to face if possible, all about the postmortem examination in detail so that they don't imagine the worst and so that they understand it is necessary in order to find out why their child died. They need to be told where it will take place, how the child will be transported there, how long it will be for, what will happen and what samples will be taken.



Q6 Will they be able to see their child again – after the postmortem?

A6 Yes, they will be given the opportunity to see their child again afterwards. It should be explained to them that a paediatric postmortem examination is done extremely carefully and sensitively, like an operation, and that the child is treated with the utmost respect and dignity.

Q7 And what does the examination consist of?

A7 The pathologist will arrange a number of investigations including a skeletal survey and the collection of tissue and organ samples for microbiology and metabolic investigations. If the paediatrician has already arranged any similar investigations, the Coroner must be informed and the results forwarded.

Q8 Do the parents have any choice in the matter?

A8 They must be informed that small tissue samples will be kept for further investigation but they should then be given the choice of whether the samples are retained (for possible future research) or returned to them once the Coroner has concluded his investigation.

Q9 How long do the investigations by the pathologist last?

A9 Depending on the nature of the case, they can take weeks or months. The preliminary results of a postmortem examination belong to the Coroner. In most cases they should be discussed by the paediatrician and the pathologist, together with the senior investigating police officer as soon as possible and the Coroner should be informed of the initial results.

Q10 What happens if the findings suggest evidence of abuse or neglect?

A10 The police, Child Abuse Investigation Unit and Local Authority children's social care should be informed immediately and a Serious Case Review should be considered by the LSCB.

Q11 Who carries out the postmortem examination?

A11 The postmortem examination is performed by the most appropriate pathologist available. This may be a paediatric pathologist, forensic pathologist – or both. It is performed according to the guidelines and protocols laid down by the Royal College of Pathologists.

Q12 Who briefs the pathologist?

A12 The consultant clinician (usually a paediatrician) should collate the information collected by those involved in responding to the child's death and share it with the pathologist conducting the postmortem in order to inform this process.

Q13 What happens if there are concerns before the postmortem examination is carried out?

A13 If the Coroner has any concerns that the death may be suspicious, then a Home Office pathologist will be used, in conjunction with the paediatric pathologist. In such circumstances, the agreed protocol will be followed in addition to any necessary forensic investigation.

Q14 How quickly does a home visit take place?

A14 Ideally, it should take place as quickly as possible – within 24 hours if possible. The arrangements should be decided at a multi-agency discussion beforehand including paediatrician, Child Abuse Investigation Unit police officer, GP, health visitor, midwife, social worker – as appropriate.

Q15 Why are so many professionals involved in arranging the home visit?

A15 It is vital that all the different agencies involved work together at every stage of the process. They should share all the information that they have gathered effectively and transparently in order to inform the home visit.

Q16 Do the parents take part in these discussions?

A16 No, but the information that they have already given when they were interviewed at the hospital will be part of these discussions.

Q17 Who takes part in the home visit?

A17 It is important that a senior healthcare professional (experienced in responding to unexpected child deaths and who may be a paediatrician), and a senior investigating police officer (probably from the Child Abuse Investigation Unit) should attend to talk with the parents and to inspect the scene – see paragraph 7.38 *Working Together*.

Q18 Do they have to go together?

A18 In most cases, a joint home visit is preferable. But if separate visits are arranged, the healthcare professional and the police officer should confer as soon as possible after the visit to share their findings and to discuss their interpretations.

Q19 What if the parents object to the home visit?

A19 It is crucial that the family understand the nature of the home visit beforehand. They should be told, in a sensitive and appropriate manner, that the scene of collapse or death will provide vital information about how their child died and help to find out whether or not such a death could have been prevented or avoided.

Q20 Will the parents already have returned home from the hospital?

A20 This is possible, but in the vast majority of cases bereaved parents choose to go to the home of a close relative or friend. It is, of course, a huge ordeal to return to the scene where their child collapsed or died.

Joint home visit

Q1 What is the point of a home visit?

A1 The home visit is extremely important in order to gather background information about the events that led up to the death and to interview parents in the environment where the collapse or death occurred.

Q2 But haven't the parents been interviewed already – in hospital?

A2 Yes, but the information that comes pouring out back at the scene of the collapse/death can be quite different from that already collected in the clinical surroundings of the hospital. It can often be much richer and more informative as the parents' memories are triggered by the immediate environment of the tragedy.

Q3 Isn't this all extremely difficult for parents? Wouldn't they prefer to be alone at a time like this? Or with close relatives?

A3 It is undoubtedly a traumatic experience for the parents. But going back to the scene of collapse or death in the company of a caring, professional team who will provide them with back up and support can actually be very helpful. It can help to provide answers about what did or didn't happen. It can even be a therapeutic process as well as an information gathering one.

Q4 How should the home visit be conducted?

A4 The parents must be treated with the utmost sensitivity. Allow them to go at their own pace and to use their own words. Let them decide where the initial discussions take place and, as the home visit will probably involve visiting more than one room, let them decide the order of rooms visited.

Q5 What kinds of questions should be asked?

A5 A detailed narrative account of events leading up to the death should be taken – including places, people, activities. Also a full account of events of the last few weeks and any changes from usual practice. Medical and family history must be taken and details of alcohol consumption and smoking in the household. Also recent exposure to infections.

Q6 Who should take the lead in the questioning?

A6 On a joint home visit it is important that the healthcare professional and the police act as a team. It is good practice to agree who will lead the questioning beforehand.

Q7 What are the different roles of the healthcare professional and the police officer on the home visit?

A7 The healthcare professional and the police officer bring very different skills to the case. The healthcare professional's background and the police officer's investigative training ensure that no clues are missed and that the delicate balance between the needs of the investigation and the support of the family is maintained.

Q8 Could anybody else take part in the home visit?

A8 The GP, health visitor, midwife or social workers, if appropriate.

Q9 Should questions be asked at the actual scene of collapse/death?

A9 When the parents are ready, a careful and thorough account of the last sleep or final events that led up to the death should be taken at the exact place where the collapse or death took place. Questions should be asked about who was where and when they were there, and the position the child was put down in, or last seen in. Details should be taken about who last saw or heard the child, where were they and was there anything unusual about this?



Q10 What about the physical examination of the surroundings?

A10 The scene should be carefully reviewed and examined and all information carefully noted. A detailed sketch plan of the room with measurements and orientation should be made and the room temperature (drawer temperature) recorded. All observations of the room, including the sleep environment and the position of baby or child, should be noted. The ventilation and heating should be inspected thoroughly. It is recommended that photographs and videos are taken for future reference.

Q11 What about the state of the room?

A11 Yes, the room should be described in every detail. Is it dirty? Is it cluttered? Is there rubbish on the floor or surfaces? Is it cramped? Is there room for an adult to stand comfortably beside the cot or bed?

Q12 What about the bed or cot?

A12 The bed or cot should be examined thoroughly. Is it defective in any way? Has it got the correct mattress? The exact position of the cot or bed in relation to other objects in the room - especially to heaters and radiators – should be noted. The mattress, the bedding and the pillows should be inspected. Are they dirty or worn? Are they the correct size? How many layers was the baby or child wrapped in? Find out the exact position of the baby or child when put down to sleep and when found.

Q13 Is there any more information that the parents should be given at this point?

A13 It is usually a good idea to give them contact details of a local funeral director, who will help to explain what they have to do next. Although this might seem premature, before the postmortem examination has been carried out, it is often reassuring for the parents.

Q14 What happens after the home visit?

A14 After the home visit, the healthcare professional and the police officer (and any other professionals who might have attended) should review whether there is any additional information that could raise concerns about the possibility of abuse or neglect having contributed to the child's death. If there are concerns about any surviving children in the household, appropriate procedures set out in Chapter 5 of *Working Together* should be followed.

Devil in the detail

Q1 What is a paediatric pathologist?

A1 A paediatric pathologist is a fully-qualified doctor, who is trained in the diseases of childhood, as well as being a pathologist.

Q2 What are the postmortem examinations like? What happens?

A2 The postmortem examinations are carried out in a specially equipped mortuary. The child is treated with great care and respect, very much like a live baby having an operation, and it is extremely important that the tissues taken are not damaged or mishandled. The parents must be told how gently and carefully their child will be treated during the postmortem.

Q3 Do many hospitals in the UK have specialised paediatric pathologists?

A3 No. There are only a few hospitals around the country which have paediatric pathologists, with the equipment and staff necessary to carry out these particular postmortem examinations.

Q4 So what happens?

A4 A child's body can be sent, with the Coroner's consent, to a hospital out of the area where there is a paediatric pathologist.

Q5 Are the parents allowed to accompany their child?

A5 No, the parents do not go with the child to the postmortem but it is vital to tell them exactly where their child is going, when she or he will come back and when and where they can see him or her again. In all stages of the processes and procedures that follow the unexpected death of a child it is vital that the parents are kept fully informed. This is part of the on-going support and care of the parents and family.

Q6 Does this delay things? Aren't postmortems meant to be done within 24 hours?

A6 Yes it can delay things slightly, depending on the area in which the death occurred.

Q7 And what about different funeral and burial customs – don't some faiths stipulate that burial must take place within 24 hours of death?

A7 Yes, it is very important to take this into consideration in a multi-cultural society and to respect and honour the different traditions. For example, Muslims start the burial process within 24 hours. But if this is impossible, the parents must be told sensitively and considerately that the postmortem is a legal requirement.

Q8 This must be very difficult for the parents, isn't it?

A8 It is, of course, but as long as it is explained carefully and sensitively, parents will understand. Above all, they want to know why their child died and the postmortem examinations will usually establish this. Parents often blame themselves and they want to be re-assured that the death was not caused by anything that they did – or didn't do.

Q9 Can a funeral take place before all the postmortem examinations have taken place and been completed?

A9 Yes, as long as the pathologist and the Coroner are fully satisfied that there is no evidence of abuse or neglect.

Q10 When is a Serious Case Review conducted following the death of a child?

A10 Whenever a child dies and abuse or neglect is suspected to be a factor in the death, the LSCB should always conduct a Serious Case Review to explore the involvement of all organisations and professionals with the child and family – see Chapter 8 of *Working Together*.

Q11 What is the purpose of a Serious Case Review?

A11 The purpose of a Serious Case Review is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children. A Serious Case Review must identify clearly what those lessons are and act on them.

Q12 So Serious Case Reviews aren't about finding who is to blame?

A12 No, Serious Case Reviews are not inquiries into how a child died or who is culpable. That is a matter for the Coroner and the criminal courts, respectively, to determine, as appropriate.

Q13 What happens when the child who died lived in a different LSCB area? For example, when parents are separated or divorced?

A13 In that case, the LSCB for the area in which the child was normally resident should take the responsibility for conducting the review. Any other LSCB which has an interest in the case should be involved with the LSCB as partners.

Q14 Who sits on a Serious Case Review Panel?

A14 Each LSCB should establish a Serious Case Review Panel involving at least Local Authority children's social care, health, education and the police to consider questions such as whether a Serious Case Review should take place.

Q15 What is the time scale of a Serious Case Review?

A15 In all cases lessons should be learnt and acted on as quickly as possible. Within one month of a case coming to the attention of the LSCB Chair, he or she should decide, following a recommendation from the Review Panel, whether a review should take place.

Q16 And how long does the review take?

A16 All Serious Case Reviews should be completed within a further four months.

Q17 Is it possible for an individual professional to ask for a Serious Case Review?

A17 Yes, any professional may refer such a case to the LSCB if it is believed that there are important lessons for inter-agency working to be learned from the case.

Q18 How is the scope of the review determined?

A18 The Review Panel should consider in the light of each case the scope of the review process and draw up clear terms of reference.



Outcome

Q1 What happens when the final results of the postmortem examination are known?

A1 A case discussion meeting should be held as soon as the final results of the postmortem examination are known. The timing of the discussion varies according to the circumstances and complexities of the death. This may range from immediately after the postmortem to eight to 12 weeks after the death.

Q2 Who takes part in this final case meeting?

A2 The number of professionals involved in the final case meeting depends on the age of the child and the agencies involved with him or her – and those investigating the death. The meeting will probably include a GP, a paediatrician and members of the Child Abuse Investigation Unit – as well as health visitor, midwife, social worker, school nurse and pathologist, as appropriate.

Q3 Who chairs this meeting?

A3 The designated paediatrician with responsibility for unexpected deaths in childhood should convene and chair this meeting. At this stage, the collection of information should be completed and, if necessary, previous information corrected.

Q4 What is the purpose of the final case meeting?

A4 The purpose of the final case meeting is to share information to identify the cause of death and the factors that may have contributed to the death. It is also to plan the future care of the family. Potential lessons to be learnt may also be identified by this process.

Q5 What about the parents? How will the information be shared with them?

A5 It should be decided at the final case meeting who will share the detailed information about the cause of their child's death with the parents. Discussion should also take place about who will offer the parents ongoing support.

Q6 When will this happen?

A6 The results of the postmortem examination should be discussed with the parents at the earliest opportunity, except in those cases where abuse or neglect is suspected and the police are conducting a criminal investigation. In these situations, the paediatrician should discuss with the Local Authority children's social care, the police and the pathologist what information should be shared with the parents and when.

Q7 What is a Child Death Overview Panel?

A7 The multi-agency Child Death Overview Panel is a sub-committee of the LSCB and is accountable to the Chair of the LSCB. The panel has a fixed membership and holds regular meetings to review cases, based on the information available from the Rapid response team and other agencies, including the Coroner.

Q8 Who are the members of the Child Death Overview Panel?

A8 The Child Death Overview Panel has a permanent core membership drawn from the key organisations represented on the LSCB, although not all core members are necessarily involved in discussing all cases. The Panel should include a professional from public health as well as child health.

Q9 Can other members be co-opted?

A9 Yes, other members may be co-opted, to reflect the characteristics of the local population – for example, a representative of a local ethnic or religious community. Or a representative from the independent or voluntary sector may be co-opted – or a specialised worker who has specific knowledge of a certain kind of death (for example, a fire fighter for a death that has occurred due to a house fire).

Q10 Who chairs the Child Death Overview Panel?

A10 The Panel will be chaired by the LSCB Chair or his or her representative, who will be a member of the LSCB. The Panel Chair should not be involved in providing direct services to children and families in the area.

Q11 What is the purpose of reviewing the cases?

A11 The purpose of the Child Death Overview Panel is to review the appropriateness of the professionals' responses to each unexpected death of a child, their involvement before the death, and relevant environmental, social, health and cultural aspects of each death, to ensure a thorough consideration of how such deaths might be prevented or avoided in the future.

Q12 What are its other functions?

A12 The functions of the Child Death Overview Panel include implementing, in consultation with the local Coroner, local procedures and protocols on enquiring into unexpected deaths, and evaluating these together with information about all deaths in childhood. Also collecting and collating information and aggregating figures, thereby identifying lessons to be learnt or issues of concern, with a particular focus on effective inter-agency working to safeguard and promote the welfare of children.

Q13 Does the Child Death Overview Panel feed back information to the various professionals who have been involved in each death?

A13 Yes, the Panel reviews the reports produced by the rapid response team on each unexpected child death, making a full record of this discussion and providing the professionals with feedback on their work.

Q14 Does each local Child Death Overview Panel have a part to play in the wider, national picture?

A14 Yes, each Panel should co-operate with both regional and national initiatives (for example the Confidential Enquiry into Maternal and Child Health or CEMACH) to identify lessons on the prevention of unexpected child deaths.

Q15 How big an area does the Child Death Overview Panel cover – is it always the same as the LSCB?

A15 No, it is recommended that the population of the area covered by a Child Death Overview Panel should be at least 500,000. So, in areas of low population, the Panel might cover more than one LSCB.

Q16 What age range does the Overview Panel deal with?

A16 The Overview Panel reviews the death of children from birth up to 18 years of age.

Q17 What does the LSCB do with the findings of the Child Death Overview Panel?

A17 The LSCB should use the aggregated findings to learn lessons and to inform local strategic planning on how best to safeguard and promote the welfare of the children in their area. The policy intention is to collect and analyse this information at a national level and to disseminate the lessons learned.



About this CD/DVD set

This drama *Why Jason Died* familiarises key professionals and their managers with the processes to be followed when a child dies. These processes are set out in the Government's statutory guidance *Working Together to Safeguard Children* (2006).

Local Safeguarding Children Boards (LSCBs) are required, from 1 April 2008, to review all child deaths in their local authority area (or areas where more than one LSCB is jointly undertaking this task), and to have in place processes to respond to, enquire into and evaluate each unexpected death to provide an understanding of the reasons for it.

The DVD is intended for a range of professional audiences. It focuses on the roles and responsibilities of those who are responding to an unexpected death of a child, and includes information about the roles of LSCBs and overview panels. The DVD is accompanied by a CD which answers questions that may be raised in the course of watching this drama *Why Jason Died*.



'We all need more improvement, we all need guidance in what we're doing. This is a very sensitive subject. It is very difficult for the families. It is difficult for the professionals as well because the most difficult thing is to talk to bereaved parents and tell them what is going happen next.'

Zala Ibrahim
Consultant Community Paediatrician,
Dudley Group of Hospitals

department for
children, schools and families