Wakefield Safeguarding Children Partnership

Flow Chart: Process for rapid response to the unexpected death of a child

Unexpected child death

First 2 - 4 hours

- Ambulance and police immediate response
- Assess immediate risks/concerns
- Resuscitation if appropriate
- Police consider appropriate scene security
- Consider needs of siblings and other family members

- Where appropriate, child and carer(s) transferred to hospital with paediatric facilities; resuscitation continued/decision to stop
- Hospital staff notify police
- Lead police investigator attends hospital

- Responsible clinician confirms death and notifies Lead Paediatrician
- Support for carer(s) and other family members
- Initial discussion between Paediatrician and attending Police Officer
- Lead Paediatrician (where possible, jointly with attending Police Officer) takes detailed history and does examination, whilst acute team take samples and performs immediate investigations

→ Hospital staff notifies
- Coroner
- CDOP office via eCDOP
- GP
- Other health organisations
- Children's Social Care

Within 24 – 48 hours

Initial information sharing (**Rapid Response)** and planning meeting/discussion co-ordinated and led by Lead Paediatrician. If abuse is known or suspected this will be a **Strategy Meeting** arranged and led by Children's Social Care. * there may be more than 1 meeting as appropriate to the circumstances of the case

→ Lead Paediatrician provides report for Coroner, Pathologist and CDOP office (via eCDOP).

Joint home visit by Police and Lead Paediatrician/health responder – (may occur before RR meeting as appropriate in the case

Coroner arranges autopsy

Autopsy and ancillary investigations

→ Preliminary and final autopsy report provided to Coroner, and with Coroner's agreement to Lead Paediatrician.

Further Police investigations –- Review of health and social care information. **Agencies complete Reporting Forms via eCDOP.**

Local Case Discussion chaired by Named Doctor/Lead Paediatrician (CDOP office provide help in arranging this meeting) – Review of the circumstances of the death – On-going family support including appropriate feedback of outcomes of Local Case Discussion

→ Report of Local Case Discussion provided to Coroner and CDOP office by Lead Paediatrician.

Coroner's Inquest

Child Death Overview Panel