Brief guidance for the management of unexpected child death by social workers – to be read in conjunction with KSCB Kent e-CDOP Unexpected Chid Death Procedures

This guidance should be read in conjunction with KSCB Kent CDOP Unexpected Child Death Procedures, KSCB Unexpected Death of a Child procedures and Kent Children's Social Work Service Death or Serious Injury to a Child (In Care and a Child in Need), all of which can be found on Tri-x.

1. The **unexpected** death of a child will be communicated to The Front Door via the professional responding to the death of a child contacting the Kent Children's Social Work Service (CSWS) or internally following Senior Managers being informed via the eCDOP system.

2. At the point of receiving the notification, a Front Door employee should check the relevant systems (Early Help Module, Liberi and Care Director Youth) and enter details onto the relevant system as below; When checking EHM it is important to check whether the case was considered to require intensive support and was subsequently closed on EHM and referred to an intensive commissioned service.

3. If the child was open to the Children's Social Work Service (CSWS) at the time of death, the Front Door employee should enter a contact onto Liberi and send the contact to the district where the child resided prior to the death in order that they can take the lead in engaging in the child death process.

4. If the child was open to Early Help, a Youth Justice Unit, has been known to Children's Social Work Service or Early Help historically but is closed at the time of the child's death or has never been known the Front Door should lead in engaging in the child death process. A contact should be added to Early Help Module.

5. If the child has not been known to CSWS, a Youth Justice Unit or EH at any point and there are no suspicious circumstances the Early Response Meeting will be health led with no need for CSWS involvement. In these circumstances, details should not be entered on to either Liberi or EHM.

When entering the details on to the relevant system:

-enter the information of surviving siblings and family members
-enter the date of death (D.O.D) and any circumstances of death known
-complete a Form A on e-CDOP if the notification of the child death has NOT come from the child Death Review Team (more information can be found at www.kscb.co.uk regarding e-CDOP).

The involvement of Early Help in the child death process should be considered in all circumstances where the child has been known to them. If the child was open to Early Help or an intensive support commissioned service immediately prior to its death, the named case worker should be invited to the Early Response Meeting and/or strategy discussion. If the

child was not open at the time of death but has been known to the service historically, a decision should be made to the appropriateness of the unit lead or Commissioned Service Manager being invited to either the Early Response Meeting or a strategy discussion.

Advice for district Social Workers about next steps – for cases where it has been agreed that the child death process will be supported by a district social work team.

1. If the child was open to the CSWS at the time of their death–
   The district Social Work team Social Worker should:
   -Inform their Team Manager of the child's death
   The district Social Work Team Team Manager should:
   -Inform the Service Manager, Area Assistant Director and Assistant Director for Safeguarding and Quality Assurance of the child's death
   -Follow up this conversation with an **alert** (form can be found on Tri-x)
   The Area Assistant Director should:
   -Inform the Director of East/West Division
   The Assistant Director for Safeguarding and Quality Assurance should:
   -Complete a Notification of Serious Child Care Incident for Local authorities to notify the National Child Safeguarding Practice Review Panel. Local authorities should continue to use Ofsted's current Notification Form for Serious Childcare Incidents to notify the Panel until a new system for the Panel goes live. Notifications made through this route will go to the Panel, Ofsted and the DfE.

2. Following the notification of an unexpected child death, an Immediate Decision-Making Discussion should be held, normally via a telephone call. This discussion will be arranged and Chaired by Health and attended by Police, district Social Work team Senior Practitioner or Team Manager and Early Help Unit Lead if appropriate. The purpose of the meeting is to decide whether an Early Response Meeting (ERM) is necessary or whether there is reasonable cause to suspect the child who died suffered significant harm and therefore a strategy discussion is necessary to safeguard any surviving siblings.

3. **Early Response Meeting (often referred to as a Rapid Response meeting)** An ERM will consider the following issues – confirmation that death was expected, liaison with other agencies, safeguarding issues (if any), scene visit update, bereavement support for family, liaison with coroner and liaison with pathologist etc.

4. Some deaths are unexplained and will require a greater depth of investigation within the response process. Most unexpected deaths will be non-suspicious, however safeguarding concerns may emerge during the ERM which will mean the meeting will need to become a strategy discussion and therefore the Chairing will need to transfer to the Team Manager who is attending.

   Strategy Discussion

5. If there is reasonable cause to suspect the child who died suffered significant harm a strategy discussion is necessary to safeguard any surviving siblings. This meeting will be Chaired by a Team Manager (or Senior Practitioner in exceptional circumstances).

6. If the child who has died is subject to a CP plan, a s47 investigation should always take place, regardless of circumstances surrounding the death if there are surviving siblings.

7. Where the child was a child in care immediately prior to their death, please see *death or serious injury to a child (in care and a child in need) procedure*.

A FORM B will be electronically requested from agency members from KSCB.

Advice for Front Door staff – for cases where it has been agreed that the child death process will be supported by the Front Door

1. Following the notification of an unexpected child death, an Immediate Decision-Making Discussion should be held, normally via a telephone call. This discussion will be arranged and Chaired by Health and attended by Police, Front Door Senior Practitioner or Team Manager and Early Help Unit Lead if appropriate. The purpose of the meeting is to decide whether an Early Response Meeting (ERM) is necessary or whether there is reasonable cause to suspect the child who died suffered significant harm and therefore a strategy discussion is necessary to safeguard any surviving siblings.

Early Response Meeting

2. An ERM will consider the following issues – confirmation that death was unexpected/expected, liaison with other agencies, safeguarding issues (if any), scene visit update, bereavement support for family, liaison with coroner and liaison with pathologist etc. Should social care support needs for the surviving siblings be identified at this meeting and the criteria for s17 services be met, a referral should be made to the district CSWT where the child resided before they died.

3. Some deaths are unexplained and will require a greater depth of investigation within the response process. Most unexpected deaths will be non-suspicious, however safeguarding concerns may emerge during the ERM which will mean the meeting will need to become a strategy discussion and therefore the Chairing will need to transfer to the Front Door Team Manager or Senior Practitioner who is attending. If a strategy discussion is necessary, the district CSWT Team Manager or Senior Practitioner where the child resided prior to death/where remaining siblings live should be invited to attend and the case transferred to the district CSWT immediately following the strategy discussion.

Strategy Discussion

4. If there is reasonable cause to suspect the child who died suffered significant harm a strategy discussion is necessary to safeguard any surviving siblings. This meeting will be Chaired by a Front Door Team Manager or Senior Practitioner and the case will be transferred to the district CSWT immediately following the strategy discussion.

A FORM B will be electronically requested from agency members from KSCB.

Responding to a child death during Out Of Hours (OOHs)

1. The unexpected death of a child will usually be communicated to the OOHs service via the police/health.

2. At the point of receiving the notification, the OOH employee should check the relevant systems (Early Help Module, Liberi and Care Director Youth) and enter details onto the relevant system as below. When checking EHM it is important to check whether the case was considered to require intensive support and was subsequently closed on EHM and referred to an intensive commissioned service.

3. At the point of receiving notification, an OOHs employee should:
   -enter the information on to Liberi as a contact for children already open to CSWS
   - enter the information on to Early Help Module as a contact for children open to EH, closed to CSWS or EH or not known to either service (where there are concerns).
   -enter the information on Liberi/EHM of surviving siblings and family members
   -enter the date of death (D.O.D) and any circumstances of death known.
   - enter the information on to Care Director Youth where relevant.
   -contact the duty on call manager (who will contact the Assistant Director if necessary)
   - follow up this conversation with an alert if necessary (form can be found on Tri-x)
   -complete the Form A on the e-CDOP system if the notification of the child death has NOT come from the Child Death Review Team (found at www.kscb.co.uk)
   -attend the Immediate Decision Making discussion (normally via telephone)

4. If it is agreed that an ERM is to be held during the next working day the case should be passed to the district Social Work team for consideration as to whether it is necessary for them to attend.

5. If it is agreed that an immediate strategy discussion is necessary, this meeting should be Chaired by an OOHs TM or Senior Practitioner, written up on Liberi and transferred to the district Social Work day team for action. Consideration should be given (if process timescales allow) for the strategy discussion to be held by the district Social Work team to enable wider professional attendance and more informed and inclusive decision making.

6. In emergencies, the OOHs worker may be expected to take action to safeguard the surviving siblings.

7. The case will be handed to the district Social Work team as soon as possible.

8. If the child was open to the CSWS at the time of death-

   The district Social Work team Social Worker should:

   -Inform their Team Manager of the child's death

   The district Social Work team Team Manager should:

   -Inform the Service Manager, Area Assistant Director and Assistant Director for Safeguarding and Quality Assurance of the child's death

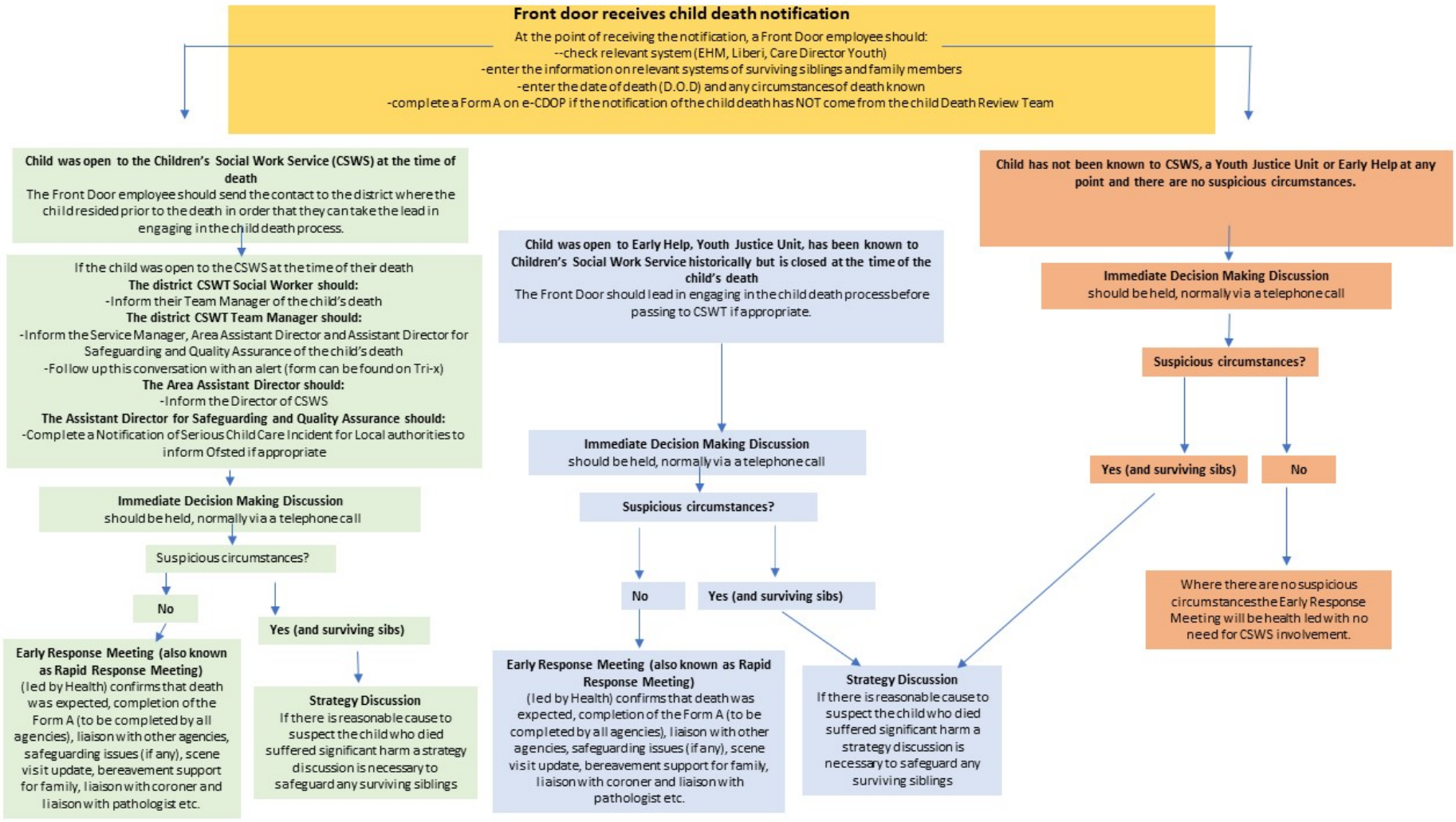
   -Follow up this conversation with an **alert** (form can be found on Tri-x) if not already completed by OOHs

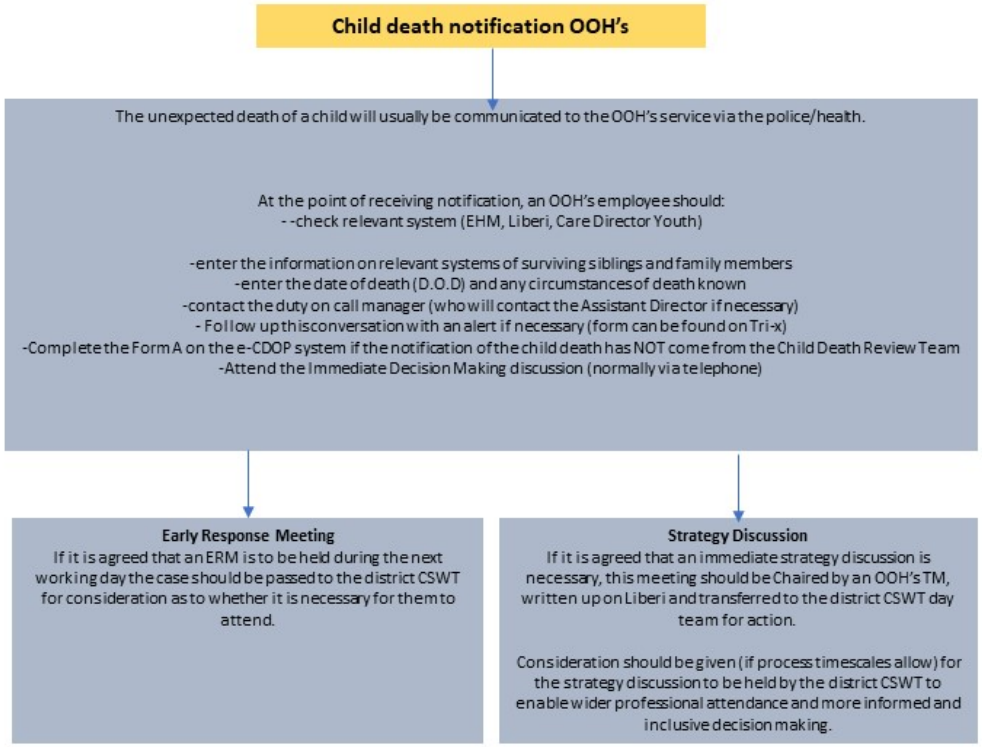
   The Area Assistant Director should:

   -Inform the Director of East/West Division

   The Assistant Director for Safeguarding and Quality Assurance should:

   -Complete a Notification of Serious Child Care Incident for Local authorities to inform Ofsted


Front door receives child death notification
At the point of receiving the notification, a Front Door employee should:
--check relevant system (EHM, Liberi, Care Director Youth)
-enter the information on relevant systems of surviving siblings and family members
-enter the date of death (D.O.D) and any circumstances of death known
-complete a Form A on e-CDOP if the notification of the child death has NOT come from the child Death Review Team
Child was open to the Children's Social Work Service (CSWS) at the time of death
The Front Door employee should send the contact to the district where the child resided prior to the death in order that they can take the lead in engaging in the child death process.
If the child was open to the CSWS at the time of their death
The district CSWT Social Worker should:
-Inform their Team Manager of the child's death
The district CSWT Team Manager should:
-Inform the Service Manager, Area Assistant Director and Assistant Director for Safeguarding and Quality Assurance of the child's death
-Follow up this conversation with an alert (form can be found on Tri-x)
The Area Assistant Director should:
-Inform the Director of CSWS
The Assistant Director for Safeguarding and Quality Assurance should:
-Complete a Notification of Serious Child Care Incident for Local authorities to inform Ofsted if appropriate
Immediate Decision Making Discussion
should be held, normally via a telephone call
Suspicious circumstances?
No
Yes (and surviving sibs)
Early Response Meeting (also known as Rapid Response Meeting)
(led by Health) confirms that death was expected, completion of the Form A (to be completed by all agencies), liaison with other agencies, safeguarding issues (if any), scene visit update, bereavement support for family, liaison with coroner and liaison with pathologist etc.
Strategy Discussion
If there is reasonable cause to suspect the child who died suffered significant harm a strategy discussion is necessary to safeguard any surviving siblings
Child was open to Early Help, Youth Justice Unit, has been known to Children's Social Work Service historically but is closed at the time of the child's death
The Front Door should lead in engaging in the child death process before passing to CSWT if appropriate.
Immediate Decision Making Discussion
should be held, normally via a telephone call
Suspicious circumstances?
No
Yes (and surviving sibs)
Early Response Meeting (also known as Rapid Response Meeting)
(led by Health) confirms that death was expected, completion of the Form A (to be completed by all agencies), liaison with other agencies, safeguarding issues (if any), scene visit update, bereavement support for family, liaison with coroner and liaison with pathologist etc.
Strategy Discussion
If there is reasonable cause to suspect the child who died suffered significant harm a strategy discussion is necessary to safeguard any surviving siblings
Child has not been known to CSWS, a Youth Justice Unit or Early Help at any point and there are no suspicious circumstances.
Immediate Decision Making Discussion
should be held, normally via a telephone call
Suspicious circumstances?
Yes (and surviving sibs)
No
Where there are no suspicious circumstances the Early Response Meeting will be health led with no need for CSWS involvement.


Child death notification OOH's
The unexpected death of a child will usually be communicated to the OOH's service via the police/health.
At the point of receiving notification, an OOH's employee should:
- -check relevant system (EHM, Liberi, Care Director Youth)
-enter the information on relevant systems of surviving siblings and family members
-enter the date of death (D.O.D) and any circumstances of death known
-contact the duty on call manager (who will contact the Assistant Director if necessary)
- Follow up this conversation with an alert if necessary (form can be found on Tri-x)
-Complete the Form A on the e-CDOP system if the notification of the child death has NOT come from the Child Death Review Team
-Attend the Immediate Decision Making discussion (normally via telephone)
Early Response Meeting
If it is agreed that an ERM is to be held during the next working day the case should be passed to the district CSWT for consideration as to whether it is necessary for them to attend.
Strategy Discussion
If it is agreed that an immediate strategy discussion is necessary, this meeting should be Chaired by an OOH's TM, written up on Liberi and transferred to the district CSWT day team for action.
Consideration should be given (if process timescales allow) for the strategy discussion to be held by the district CSWT to enable wider professional attendance and more informed and inclusive decision making.