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

First 2 – 4 hours

Unexpected child death

- 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

Within 24 – 48 hours

- 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

- 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 Childrens Social Care. * there may be more than 1 meeting as appropriate to the circumstances of the case

- 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

- Further Police investigations — Review of health and social care information. Agencies complete Form B’s and send to Child Death Office

1 – 6 months

- 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

- Coroner’s Inquest

- Child Death Overview Panel

Hospital staff notifies:
- Coroner
- CDOP Office
- GP
- Other health organisations
- Children’s social care

Lead Paediatrician provides report for Coroner, Pathologist. And CDOP office

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

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