**(JAR)** **Short Guide- Joint Agency Response**

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# Short guide - Joint Agency Response (JAR)

Following the notification of an unexpected child death, an Immediate Decision-Making Discussion will be held within the Health Service (needing no involvement from Children’s Social Work Services at this time), which will decide whether a Joint Agency Response (JAR) should be triggered. See: [Kent Escalation and Professional Challenge Policy - April 2023](https://www.kscmp.org.uk/__data/assets/word_doc/0010/131869/Kent-Escalation-and-Professional-Challenge-Policy-April-2023-final.docx)

## A JAR should be triggered if a child’s death:

* + - is or could be due to external causes
		- is sudden and there is no immediate apparent cause including Sudden Unexpected Death in Infancy/childhood (SUDI/C)
		- occurs in custody, or where the child was detained under the Mental Health Act
		- where the initial circumstances raise any suspicions that the death may not have been natural
		- in the case of a stillbirth where no healthcare professional was in attendance

Additionally, a JAR should be triggered if a child is brought to a hospital near death, and the child is successfully resuscitated, but expected to die in the following days.

## JAR Meeting

If it is agreed by Health that a JAR Meeting is necessary, itwill be arranged and Chaired by a health representative, usually the Designated Doctor. The agenda involves:

* Introductions and apologies
* Background information
* Information from agencies including any scene visit update
* Liaison with coroner and pathologist. Post-mortem information (if available at time of JAR)
* Keyworker (to be allocated)
* Name of lead consultant (to be allocated)
* Risks to surviving siblings or other children
* Bereavement support for family (confirmation who will provide support)
* Staff debrief (confirmation of if this has taken place / is planned)
* Discussion if circumstance meet Serious Incident (SI), National Panel, or internal review criteria *–* see below*.*
* Any other business

Minutes are taken and should be distributed when authorised by the designated doctor.

For further information, including around attendees see[Managing an Unexpected Child Death (Guidance for FDS)](https://www.proceduresonline.com/trixcms2/media/12824/managing-an-unexpected-child-death-guidance-for-fds.docx) (found on kent procedures online).

## Serious Incident (SI)

The SI framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. See the link: [NHS England » Serious Incident framework](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fpatient-safety%2Fserious-incident-framework%2F&data=05%7C01%7CAnna.Messinger%40kent.gov.uk%7Cfcdfd69a71494b151f0308db0829a891%7C3253a20dc7354bfea8b73e6ab37f5f90%7C0%7C0%7C638112747252816420%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=VCf8T1xuRXsYAnJdHbD4%2FA6fgk7i7wlhRafsESpspOo%3D&reserved=0) (By Autumn 2023 it will be rolled out and known as PSIRF – [Patient Safety Incident Response Framework (PSIRF)](https://www.england.nhs.uk/patient-safety/incident-response-framework/).

Anyone can raise a SI. There is not one person who has responsibility for this. If it is agreed as single agency SI, the agency is responsible for investigating, consideration to any learning and follow up actions and will complete a report. They may not share the report.

If the Child Death Review Service are able to obtain a copy of the report, this would be stored with Child Death Overview Panel (CDOP) but not distributed to other agencies unless specifically requested by the single agency. The CDOP Review Panel would discuss everything related to the child including the report and learning outcomes/actions before closing the child on CDOP.

## Child Safeguarding Practice Review Panel (aka National Panel) recommendation:

Local authorities in England must notify the National Child Safeguarding Practice Review Panel (the Panel) within 5 working days of becoming aware of a serious incident.

Serious incidents which should be reported are those where the local authority knows or suspects that a child has been abused or neglected and:

* The child dies (including suspected suicide) or is seriously harmed in the local authority’s area;
* While normally resident in the local authority’s area, the child dies or is seriously harmed outside England.

**The decision for a referral to be made to the national Panel is made by the Director with the notification processed by the Safeguarding Unit.**

Two points to note from “Child Safeguarding Practice Review Panel guidance for safeguarding partners September 2022”.

* If the child was already open and there was sufficient concern to trigger a strategy discussion, section 47 investigation, or care proceedings, or evidence to initiate a criminal investigation for possible abuse or neglect, then that indicates that abuse or neglect is at least suspected. Therefore, the criteria would therefore have been met.
* In cases of physical injury which are neither life-threatening, nor life-changing, consideration should be given to the extent, persistence and severity of the injuries sustained and any context of wider neglect or abuse. Isolated bruises or limb fractures in infants or children would not normally be considered serious unless accompanied by internal injuries (for example abusive head trauma, abdominal injuries) or they are of a degree or extent likely to be life-threatening or life changing.

[Child Safeguarding Practice Review Panel Guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1108887/Child_Safeguarding_Practice_Review_panel_guidance_for_safeguarding_partners.pdf)

**Internal Review**

If it does not meet the threshold for National Panel, in some situations an internal review may be completed to identify any learning.

## Escalation regarding a JAR

If there is a difference of opinion about whether the threshold is met for Serious Incident (SI), National Panel, or an internal review this should be raised in the JAR and can be noted in the minutes.

If there are concerns about how the JAR was conducted, or decisions and actions need to be challenged further, this can be raised with the Child Death Coordinator and should be raised with the designated Doctor who held the JAR meeting. A formal [escalation form](file:///C%3A%5CUsers%5CFearnS01%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CERDIS1PS%5CSearch%20-%20Kent%20Safeguarding%20Children%20Multi-Agency%20Partnership%20%28kscmp.org.uk%29) can be used (found at kscmp.org.uk).

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