Croydon Rapid Response Meeting

Terms of Reference

(To be read in conjunction with Chapter 5 'Working Together to Safeguard Children' March 2015 HM Government)

The Rapid Response (RR) process applies when a child dies unexpectedly (birth up to 18th birthday), excluding babies who are stillborn or whether there is lack of clarity about whether the death of a child is unexpected.

An unexpected death is defined as the death of a child not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.

Deciding on whether the death is unexpected and whether to implement the RR process is the responsibility of the designated paediatrician responsible for unexpected deaths in childhood.

Purpose

The purpose of the RR meeting, which is an element of the RR process, is to have a multi-agency case discussion to share information about the cause of death or factors that may have contributed to the death and to plan future care of the family.

This meeting ensures that the appropriate agencies are engaged and work together to:

- Respond quickly to the unexpected death of a child in accordance with locally agreed procedures
- Ensure support for the bereaved families, as the death of a child will always be a traumatic loss, more so if the death is unexpected.
- Ensure all relevant agencies are involved in the process and are aware of their roles and responsibilities
- Identify any safeguarding concerns around other children in the household or affected by the death
- Making immediate enquiries into and evaluating the reasons for and circumstances of the death , in agreement with the coroner as required
- Collate information in the standard format
- Cooperate appropriately post death, maintaining contact at regular intervals with family members and other professionals who have on-going responsibilities to the family, to ensure that they are appropriately informed (unless such sharing of information would place other children at risk of harm or jeopardise police investigations)
- Consider media issues and the need to alert and liaise with the appropriate agencies
- Consider bereavement support for any other children, family members or members of staff

Attendance at Rapid Response Meeting- Representation from lead agencies & services involved

- Designated Doctor for Child Protection & Child Death Reviews
- Head of Safeguarding, Designated Nurse Children (Croydon Clinical Commissioning Group)
- Named Nurse Safeguarding and Child Protection (Croydon Health Services)
- Croydon Single Point Of Contact (SPOC) & Child Death Review Coordinator
- Paediatrician
- Social Care Operational Manager
- Hospitals where the child has died out of area
- Children's Hospital at Home (CHAH)
- London Ambulance Service (LAS)
- Police
- GP
- Child & Adolescence Mental Health Services (CAMHS)
- Education
- Health Visitors
- Croydon University Hospital (CUH) Paediatric Staff-A&E Matron & Clinical Nurse Manager
- Helicopter Emergency Medical Service (HEMS)
- Midwifery
- Speech & Language Therapy (SALT)
- Physiotherapy
- Family support services
- Hospice
- School Nurses
- Deputy Designated Nurse, Commissioning on behalf of Independent Contractor Services
- Any other relevant agency/service

The meeting will be chaired by either the Designated Doctor for Child Protection & Child Death Reviews or the Head of Safeguarding, Designated Nurse Children (Croydon Clinical Commissioning Group).

Confidentiality

- All attendees will be required to sign a confidentiality agreement / attendance sheet before participating in the meeting to confirm that they have understood the requirements of confidentiality.

- Any confidential information will be transferred securely

Accountability

The RR will report to the local Child Death Overview Panel who are accountable to the Croydon Safeguarding Children Board

Frequency of meetings

RR meetings will be considered as a priority and be convened within 5 working days where possible, of the child's death

A second meeting may be convened if required

Follow-up of actions

- Actions agreed and logged at the RR meeting will be detailed in an action plan which accompanies the minutes. This will be followed up by the Croydon SPOC & Child Death Review Coordinator
- Any identifiable information will be anonymised prior to review by the local Child Death Overview Panel
- Distribution of minutes to all attendees and core members (regardless of their attendance).

The Terms of Reference will be reviewed annually

Relevant papers:

- Croydon Multi-agency Child Death Notification Protocol
- Croydon Rapid Response Flow Chart
- Form A - Initial Notification of the death of a child
- Child Death RR meeting Confidentiality Statement
- Child Death RR Meeting Agenda

August 2015