Rapid Response Process

One Minute Guide

It is the responsibility of the LSCB to ensure that a review of each death of a child normally resident in it's area is undertaken by CDOP.

What is an 'unexpected death'?

Working Together 2015 defines the unexpected death of a child which was 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.

What is the purpose of a Rapid Response Meeting?

Rapid Response describes the process of communication, collaborative action and information sharing following the unexpected death of a child. The purpose of a Rapid Response meeting is to ensure that the appropriate agencies engage and work together to:

- Respond quickly to the unexpected death of a child.
- Make immediate enquiries into and evaluate the reasons for and circumstances of the death, in agreement with the coroner.
- Undertake enquiries/investigations that relate to the current responsibilities and actions of each organisation when a child dies unexpectedly. This includes liaising with those who have ongoing responsibilities for other family members.
- Collate information in a standard, nationally agreed manner.
- Work together appropriately post death, keeping contact with family members and relevant professionals to ensure that they are appropriately informed.

Rapid Response begins at the point of death and ends with the completed report to the Child Death Overview Panel.

The first phase of the response will be within the first few hours when an information sharing and planning discussion or meeting takes place most usually between the Consultant and hospital staff, the Police and the Coroner.

The second phase brings together a multi-agency team co-ordinated by the Sudden Unexpected Death in Infancy (SUDI) doctor or the Police. The '**rapid response**' meeting should take place within 48 hours after the unexpected death of a child.

The professionals involved will carry out their normal functions for example as a GP, Paediatrician, Midwife, Health Visitor, Police Officer or Social Worker, but will work in accordance with the guidance within Working Together 2015.

This guidance has been developed locally and is contained within the North Yorkshire Safeguarding Children Board and City of York Safeguarding Children Board Procedures.

A 'phase three' meeting brings together all the professionals involved and takes place after the post-mortem examination results are complete, but prior to inquest (where applicable).

Following the inquest (if applicable) each case is reviewed by the Child Death Overview Panel to;

- Classify the cause of death.
- Identify any modifiable factors.
- Consider whether to make recommendations and whom they should be addressed by.

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