What is a Joint Agency Response?

It is the responsibility of Child Death Review Partners (Local Authorities and CCG's) to ensure arrangements for the review of each child that dies who is normally resident in their area.

A Joint Agency Response is a process for reviewing child deaths whereby a team of key professionals come together for the purpose of enquiring into and evaluating each unexpected [1]death of a child. Meetings held throughout the JAR are mandated under the Sussex Joint Agency Response protocol for Unexpected Deaths procedures in accordance with Working Together to Safeguard Children 2018, Chapter 5.

A Joint Agency Response will be triggered if a child's death:

- Is or could be due to external causes;
- Is sudden and there is no immediately apparent cause of death (incl. SUDC);
- 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, and
- If a child is brought to hospital, near death and is successfully resuscitated but is expected to die in the following days.

What is the Initial Information Sharing and Planning Meeting (IISPM)?

It is a multi-agency meeting held following the death of a child (usually by the next working day) where a Joint Agency Response is required. This is jointly planned by the Senior Investigating Officer, Lead Health Professional and Children's Social Care. This meeting will be arranged and chaired by Children's Social Care where the child was resident.

Multi-agency professionals and specialist agencies that have been involved with the child/family will be requested to attend. Some agencies may not have known the child in life. Those who may be invited, in addition to lead health professional, investigating officer and children's social care include:

- General Practitioner
- Midwife
- Health Visitor/School Nurse
- Police Coroners Officer
- Hospital staff during the resuscitation
- Ambulance crew
- Other doctors or AHP caring for the child in life
- Education

What is the Purpose of the Initial Information Sharing and Planning Meeting (IISPM)?

The purpose of this early meeting is to share and discuss pertinent information agencies hold in relation to the death of a child;

- Consider the possible causes of death, ascertain if there are any safeguarding concerns
- Plan future care and support of the family, including who will provide the family with information about support groups, bereavement, etc.
- Identify support for the child's immediate and extended peer groups and professionals
- Identify any immediate learning to be shared
- Share information from each agency's previous knowledge of the family and records. In particular any reference to the circumstances of the child's death; previous or ongoing child protection concerns, previous unexplained or unusual deaths in the family; neglect, failure to thrive, parental substance abuse, mental illness or domestic violence. Information is also required about family members and others involved with the child. Evidence of good care and parenting is also sought.

[1] Unexpected death refers to the death of a child (less than 18 years of age) that was not anticipated as a significant possibility 24 hours before the death or where there was an unexpected collapse leading to or precipitating events that led to the death.

- Enable consideration of any child protection risks to siblings/any other children living in the household and to consider the need for child protection procedures and any other action, for example health overview for other children in the family.
- Agree whether a follow-up meeting should be held (usually after the final post mortem examination report is available and permission to share the result has been given by the coroner)
- Identify a plan to convene for a final case review (CDRM) ideally before a coroner's inquest (in required);
- Identify any other actions that may be necessary
- Agree whether a referral should be made to the child safeguarding partnerships for consideration of a rapid review

The agreed meeting minutes will be shared with Pan-Sussex Child Death Overview Panel to inform their independent review, the relevant Coroner and the Pathologist for potential investigations.

Expectations for attendees at an IISPM

- All attendees are expected to engage and provide information that is held about the child and family.
- Attendees should be prepared and aware prior to attending an IISPM that sensitive confidential information will be shared which could be very distressing and have an emotional impact if you have known the child in life.
- Discussions may be held in respect of historical information, Social Care information, events leading to the death and the health care provided to the child such as:
    - Injuries to the child (intentional or non-intentional).
    - Emergency medical intervention provided to the child.
    - Accounts of events leading to the death of the child.
    - Potential Police investigations.
    - Environment in which the child may have been found.

- Dependant on circumstances, there will be a pre-meeting with medical staff and initial responders to discuss specific circumstances surrounding the death and clinical details that may not be appropriate for open discussions. Nursery/Schools etc will not be invited to this pre-meeting however a sanitised overview will be provided to all attendees of the IISPM.
- The information shared at the IISPM and the minutes are strictly confidential and should only be shared within your organisation on a need to know basis. The information shared and the meeting minutes must not be shared outside of your organisation without prior consent from the chair or CDR Partnership (LA and CCG) and those sharing the information. Please ensure the information and meeting minutes are stored in line with your organisations Data Protection and Confidentiality procedures.

Steps following the IISPM

Dependant on what actions arise from the death, there may be requests for further information from agencies who are tasked with reviewing/investigating the death.

- In some circumstances, a subsequent follow-up IISPM meeting may be required; this will be arranged by Children's Social Care to discuss any emerging/new information.

- In accordance with The Children Act 2004, Child Death Overview Panels were established to conduct reviews for all child deaths, regardless of the cause. Agencies who hold information pertinent to the care or death will be required to complete a 'CDOP Reporting Form' to document their services input and allow for thorough analysis. All information collected by CDOP's are shared with the National Child Mortality Database (NCMD) for interpretation and analysis on all child deaths across England. There is a legal requirement for organisations to comply with this request.

- If the death is referred to the child safeguarding partnerships for consideration of a rapid review – agencies may be required to complete an information request.

- Once the final Post Mortem Examination report is available and any necessary information, such as outcomes from any investigations have returned. Professionals who have been involved with the child/family should be invited to attend a Child Death Review Meeting. This will be the final meeting of the JAR process and held before a coronial inquest. At this meeting, professionals will review all information in order to clarify the likely cause of death, identify whether there were any contributory or modifiable factors, describe any learning from organisations involved and review the support needs of the family. The minutes from this meeting will be sent to the coroner and to the CDOP.