Children's Family Help and Safeguarding

Responding to death or serious incidents protocol

1 Purpose and scope

This protocol sets out what actions should be taken following the death of a parent or child known to Children's Family Help and Safeguarding (CFHS) or a serious incident occurs to a child who is known to Children's Family Help and Safeguarding. The protocol also details how staff should be supported following a death or serious incident.

2 Overview of processes involving death or serious harm to a child

Working together to safeguard children (2023) sets out 2 process that the Camden Safeguarding Children Partnership (CSCP) must follow when a child dies or there has been a serious incident involving a child.

Child safeguarding practice reviews: Where a child has died or suffered significant harm following a serious incident, and this is attributable to known or suspected abuse or neglect, a serious case learning review must be carried out to identify any learning points around safeguarding systems and practice and any improvements that can be made to keep all children safe in future.

Child death review: Where a child dies unexpectedly, the Camden Safeguarding Children Partnership must carry out a child death review to look at the circumstances of the death so that parents have an understanding of what happened and to inform agencies of any learning or improvements that can be made to services to better promote the safety and welfare of children,

Both of these processes are overseen by the Camden Safeguarding Children Partnership who will co-ordinate the multi-agency response and make arrangements for meetings in which relevant information is gathered to inform the processes. Children's Family Help and Safeguarding workers and their managers will generally be expected to contribute to information-sharing meetings on cases allocated to them as part of both these processes. Details of the processes can be found in the flow charts at Appendix 2 and 3.

Inquests: Inquests are held in order to establish the circumstances of a death, usually where the cause of death is unknown, occurs in violent circumstances or while the person is detained. In the event of the death of a parent or child known to Children's Family Help and Safeguarding in these circumstances, Children's Family Help and Safeguarding may be asked to either provide disclosure of documents or witness statements to the Coroner's Court. A staff member, most likely an allocated worker, may also be called on to give evidence to an inquest. For more details please refer to the *Inquest disclosure procedure* available at: inquest-disclosure-procedure.pdf (camden.gov.uk)

Please note that these processes may be ongoing at the same time.

3 Notifications under the protocol

- All staff should be aware of the process for reporting incidents involving the death or serious injury of a child in Camden to senior managers, council leaders and the Press Office as set out in the Reporting Serious Incidents protocol shown at Appendix 1 and available at: flow-chart-for-reporting-serious-incidents-within-csfh.pdf (camden.gov.uk)

- When notified of the death of a parent or child, the Multi Agency Safeguarding Hub (MASH) manager should notify the line manager of the allocated worker who is currently working with or recently worked with the child/parent who has died via email (this information can be found on MOSAIC; the Multi Agency Safeguarding Hub also have a list of managers assigned to each Early Help service).

- In the absence of the line manager (usually the team manager), the Multi Agency Safeguarding Hub should contact the relevant service manager or in their absence, the Head of Service.

- Death and serious incident involving a child receiving a service from Children's Family Help and Safeguarding must be notified to the service manager of the Camden Safeguarding Children Partnership (CSCP).

- The Camden Safeguarding Children Partnership will notify the National Child Safeguarding Panel of any death or serious incident involving abuse or neglect within 5 working days.

- Team managers are responsible for informing the worker of the death or serious incident immediately and explain the next steps that will happen under this protocol. If the team manager is absent, this should be done by the relevant service manager or Head of Service.

- If the allocated worker is absent from work, and there has been prior agreement on contacting them whilst absent in the event of a death or serious incident, the service manager and team manager should agree to follow this process and inform the worker. Such agreements should be explored in supervision with all staff on how they would like to be notified and this should be and recorded in their supervision file.

4 Action by team managers and allocated workers

The manager should meet with the worker to carry out the following:

- explaining the next steps to be taken including any steps under the safeguarding review process or child death review process
- carrying out a review of the family together
- discussing the worker's support needs, ensuring the worker is aware of the support they can access (see section 8) and deciding if the worker needs time away.

Where a child or parent has died, the team manager should also ensure that their MOSAIC profile is amended to display 'deceased' and the date of their death.

In the event of the death of a child or a serious incident of harm to a child, either of the processes described above may be followed and the allocated worker will be expected to provide information from the case file so it is important that the file is up to date and all recording completed.

The service manager should read over the case file and identify any strengths, gaps and areas for learning and communicate these to the worker and team manager with feedback given regarding the family and practice as a whole rather than limited to the death. This should be done in person and within 2 weeks of the notification.

5 Procedures under child safeguarding practice reviews

Sometimes a child suffers a serious injury or death as a result of abuse or neglect. Reflecting on how well that system is working is critical in improving our response to children and their families.

Child protection is a complex multi-agency system with many different organisations and individuals playing their part. Understanding not only what happened but also why it happened can help improve responses in the future. Appreciating the impact that organisations and agencies had on the child's life, and on the lives of their family members, and whether or not different approaches or those actions could have resulted in a different outcome, is essential.

The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the national panel) and at a local level with the safeguarding partners of the Camden Safeguarding Children Partnership. Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected
- the child has died or been seriously harmed.

Serious harm includes (but is not limited to) serious and / or long-term impairment of a child's mental health or intellectual, emotional, social, or behavioural development.

Camen is required to notify the national panel of any incident that meets the above criteria within five working days of becoming aware it has occurred. A template is available to enable the relevant information to be collated in a timely manner, when it is considered that the criteria has been met for a serious incident notification.

Following making the notification, the Camden Safeguarding Children Partnership will be required to promptly undertake a Rapid Review meeting. The purpose of this meeting is to:

- gather the facts about the family and the work that has been delivered with them
- discuss whether any immediate action is needed to ensure children's safety and share any learning
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide what steps the Camden Safeguarding Children Partnership should take next, including whether to undertake a child safeguarding practice review.

The process for local child safeguarding practice reviews is illustrated in the flowchart at Appendix 1.

The meeting will be held as soon as possible after the event but should be held within 10 working days, in order for the Rapid Review report to be submitted to the national Child Safeguarding Practice Review Panel within 15 working days from the notification. The meeting is convened by the Camden Safeguarding Children Partnership who will liaise with the safeguarding partners to agree meeting arrangements to ensure independence.

Prior to the meeting, all agencies working with the child and family will be asked to complete a chronology of events detailing the agency's involvement with the family. For Children's Family Help and Safeguarding, the Quality Assurance teams from Early Help and Children's Safeguarding and Social Work will carry out a case audit and complete the form provided by the Camden Safeguarding Children Partnership.

The team manager should attend the Rapid Review Meeting and the worker may also attend the meeting if this is thought to be appropriate. In the event the team manager is absent, the relevant service manager and covering team manager will decide together who should attend in their absence.

The meeting should be attended by all those working with the child and family including:

- the relevant Early Help or social work team manager (and allocated worker if appropriate)
- a representative from MASH
- a representative from the Quality Assurance Unit
- a representative from Health
- a representative from the Police
- a representative from the child's school or nursery.

The meeting will share information and reflect on the learning and a decision will be taken to report to the National Child Safeguarding Panel to request that a local Child Safeguarding Practice Review is carried out.

The meeting will be minuted and a report will be prepared by the Camden Safeguarding Children Partnership for the national panel. The Early Help or social work team manager is responsible for uploading any actions or recommendations from the meeting on the child's MOSAIC file and discussing these with the allocated worker so that these are taken forward.

If the national panel agrees that a local child safeguarding practice review should take place, this will normally take place within 6 months. The Camden Safeguarding Children Partnership will appoint an independent person to carry out the review and will inform managers and workers of the need for them to contribute information from the file.

Information is normally gathered via a reflective meeting with the reviewer who will discuss events with all the professionals and agencies who worked with the family including the social worker and their manager. The findings and recommendations from their report will then be disseminated to agencies.

6 Procedures under child death review process

The process for child death reviews is illustrated in the flowchart at Appendix 2. The North Central London Child Death Overview Panel will notify managers when a Joint Agency Response (JAR) planning meeting will be held and how workers will need contribute to this process.

Joint Agency Response meetings are held where the child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause
- 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; or
- in the case of a stillbirth where no healthcare professional was in attendance.

The Joint Agency Response meeting will be convened by the North Central London Child Death Overview Panel with Child Death Review (CDR) partners and chaired by a health professional. The purpose of the meeting is to ascertain the circumstances of the child's death and gather information for the Child Death Review meeting. The Designated Safeguarding Lead from each agency attends this.

You may be invited to a Joint Agency Response if:

- you have been identified as a key professional in the child's or family's life;
- you have been working with the family on a professional basis;
- you were involved in the emergency response to the child's death;
- you have information on the child and family's health, education and social history;
- you have a professional responsibility to review and investigate the circumstances of the child's death;
- you will be expected to provide support to the wider family;
- you may be the best person to be the key worker for the family.

The outcome of the Joint Agency Response may lead to the:

- raising and consideration for a Rapid Review led by the Local Authority
- raising consideration for a Serious Investigation in any of the agencies.

Team managers and allocated workers are expected to attend the multi-agency Child Death Review meeting.

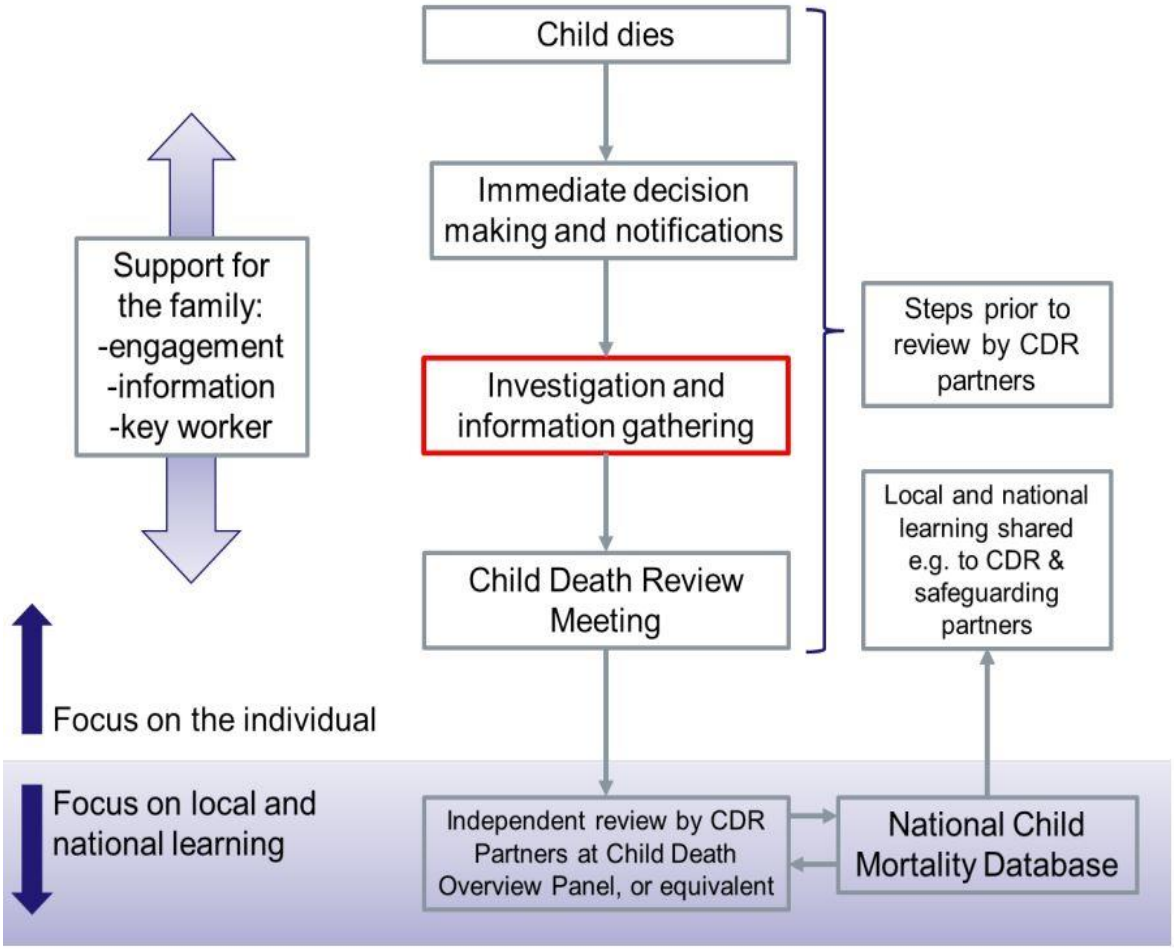
Workers should expect to hear:

- highly confidential and distressing information on the events surrounding the child's death
- highly distressing information on the emergency response and family reactions at the time of the death
- highly confidential information on the child's family health and social history
- highly confidential information regarding the child's lived experience.

Workers are expected to share the following information:

- provide an explanation of their role and involvement in the child's life
- provide a high- level summary of Children's Family Help and Safeguarding involvement with the child, their parents and wider family
- answer questions regarding their interactions with the child and their family.
- their job title and input to be shared with the Coroner (if requested)

Child Death Review Process



7 Supporting families and future work

Children's Family Help and Safeguarding will need to work with families experiencing bereavement, loss and the aftermath of serious incidents and trauma associated with these in order to support them. People may also react differently to when a loved one dies. Further information about individual reactions to death can be found here An Individuals Reactions to Bereavement (HR).pdf

Workers should be aware of resources for bereaved parents such as Cruse and the Lullaby Trust, and children who have lost parents, such as Winston's Wish and Young Minds. More information from HR regarding speaking to families about bereavement is also available here Suggestions for Speaking with Bereaved Individuals (HR).pdf

Workers should be aware of the Bereaved Families Protocol on how workers can support families who have lost children due to serious youth violence, available at: Bereaved families protocol | Children's Policy & Practice Hub (camden.gov.uk)

As part of the Child Death Overview Panel process, all bereaved families will be given a named key worker who will be their single point of contact and whose role is to provide information on the child death review process and signpost them to sources of support. Social workers and Family Support Workers may be asked to be the key worker if they are involved with the family already or as part of an investigation, for example as Family Liaison Officer.

Workers should be aware that they can seek support from their manager post Joint Agency Response or liaise with the local safeguarding lead.

Additional resources for professionals - supporting yourself and your colleagues | Child Bereavement UK

Child Bereavement UK Helpline for practitioners 0800 02 88840 or/and email helpline@childbereavementuk.org.

Further information :
https://www.ncmd.info/guidance/
https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
Supporting bereaved families | Child Bereavement UK
When a child dies nhs leaflet - Search (bing.com)
https://sudc.org.uk/

The North Central London Child Death Overview Panel (NCL CDOP) - Camden Safeguarding Children Partnership CSCP

The North Central London Child Death Overview Panel (NCL CDOP) - North Central London Integrated Care System (nclhealthandcare.org.uk)

For Early Help families where there has been a death or serious incident involving a child and abuse and neglect are present, managers should consider stepping up the family to statutory social work services.

In general, families will remain with the allocated worker and team unless there is good reason to change allocation. Often families welcome support from professionals with whom they have good relationships at this stressful time and workers will have a key role to play in supporting them.

8 Support for staff

Dealing with the death of a parent or child or a serious incident is likely to lead to workers experiencing some level of trauma. These events may also trigger negative memories from their own life experiences or where workers are having difficulties in their own lives.

As Camden has a duty of care to employees and must take action to protect their health, safety and wellbeing whilst at work, managers must be able to recognise when social workers are struggling with the emotional impact of these events and ensure that action is taken as soon as possible to help them address any trauma.

Workers should be given an opportunity to discuss their emotional wellbeing in a safe space, such as supervision, and encouraged to open up about any difficulties they may be having. Managers should be aware of the offer of help available from the following:

Support for all Camden Staff including Early Help workers and Social Workers

- Camden's Employee Assistance Programme (EAP), provides free, confidential counselling support which is available 24-hours-a-day, every day of the year – and can be accessed by workers and their family. It is provided by an external company called Workplace Options. It can be accessed by website, app or by phone. The Phone number 0800 243 458. For more information use this link Employee Assistance Programme.

- The Employee Assistance Programme can also provide a Rapid Response Critical Incident (RRCI) service through on-site and/or virtual emotional support to staff to individuals and as part of a group as required. The RRCI support can be arranged by contacting Camden's Health and Safety Manager Darren Williams (darren.williams@camden.gov.uk, Tel: 020 7974 2117, Mob: 07824 418488)

- All employees also have access to free, confidential trauma support. There are currently three providers, providing grief and trauma coaching, emotional support and listening spaces as well as counselling. More information can be found here Wellbeing support for colleagues affected by trauma

- A range of bereavement support services ranging from helplines, information services and counselling services. The information on this page may be useful to colleagues Bereavement support

Support for the Early Help Service

In addition to the support above in the Early Help Service emotional support is available to both the allocated worker and the line manager via a one off space from Educational Psychology to talk about the death of the child or parent that was supported by the service, how this has impacted on the worker and identify any next steps or support that may be beneficial to them. This is a reflective space, not an ongoing offer of emotional support. Should the allocated worker and/or team manager feel they could benefit from the support from Educational Psychology, the Team manager should contact Sarah Cryer (sarah.cryer@camden.gov.uk

Support for social workers

The Tavistock Clinic offers Camden social workers up to 4 sessions of counselling and signposting on to other support and resources. The offer can be accessed via CAMHS and managers should contact the CAMHS Clinical service manager to discuss the social worker's needs confidentially and the CAMHS representative will contact the Tavistock to make arrangements for a worker there to make contact with the social worker to organise sessions. Although every effort will be made to ensure social workers see a clinician promptly, this is not an extensive service and staff may experience delays.

CAMHS can also offer up to 2 meetings to support and debrief teams following a death or serious incident that affects the entire team. Team managers can contact the CAMHS Clinical Service manager to discuss accessing this resource.

CAMHS Clinical Service Manager: Patricia Pemberton – ext: 8797 – patricia.pemberton@camden.gov.uk

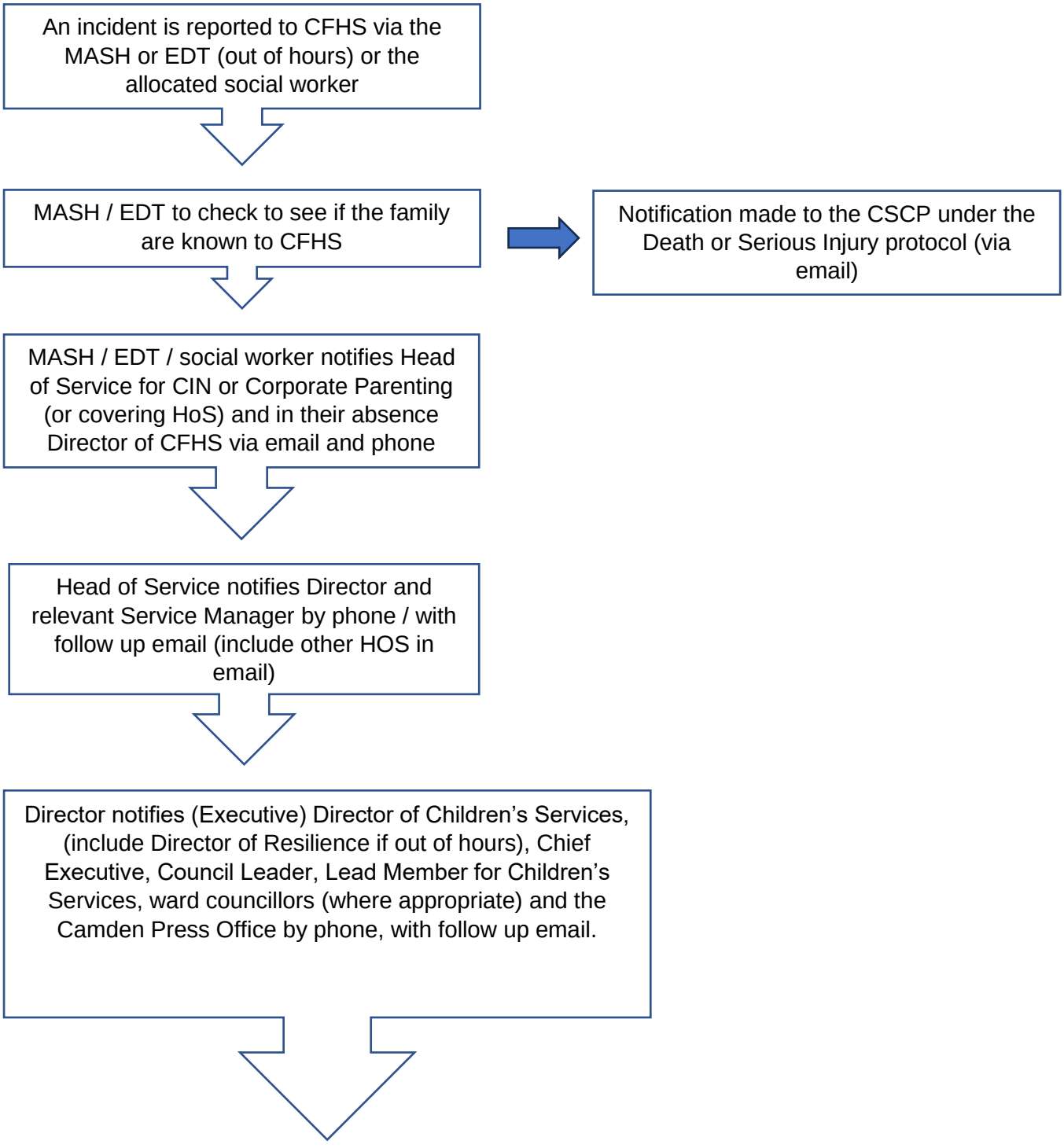
Appendix 1

Reporting of serious incidents protocol

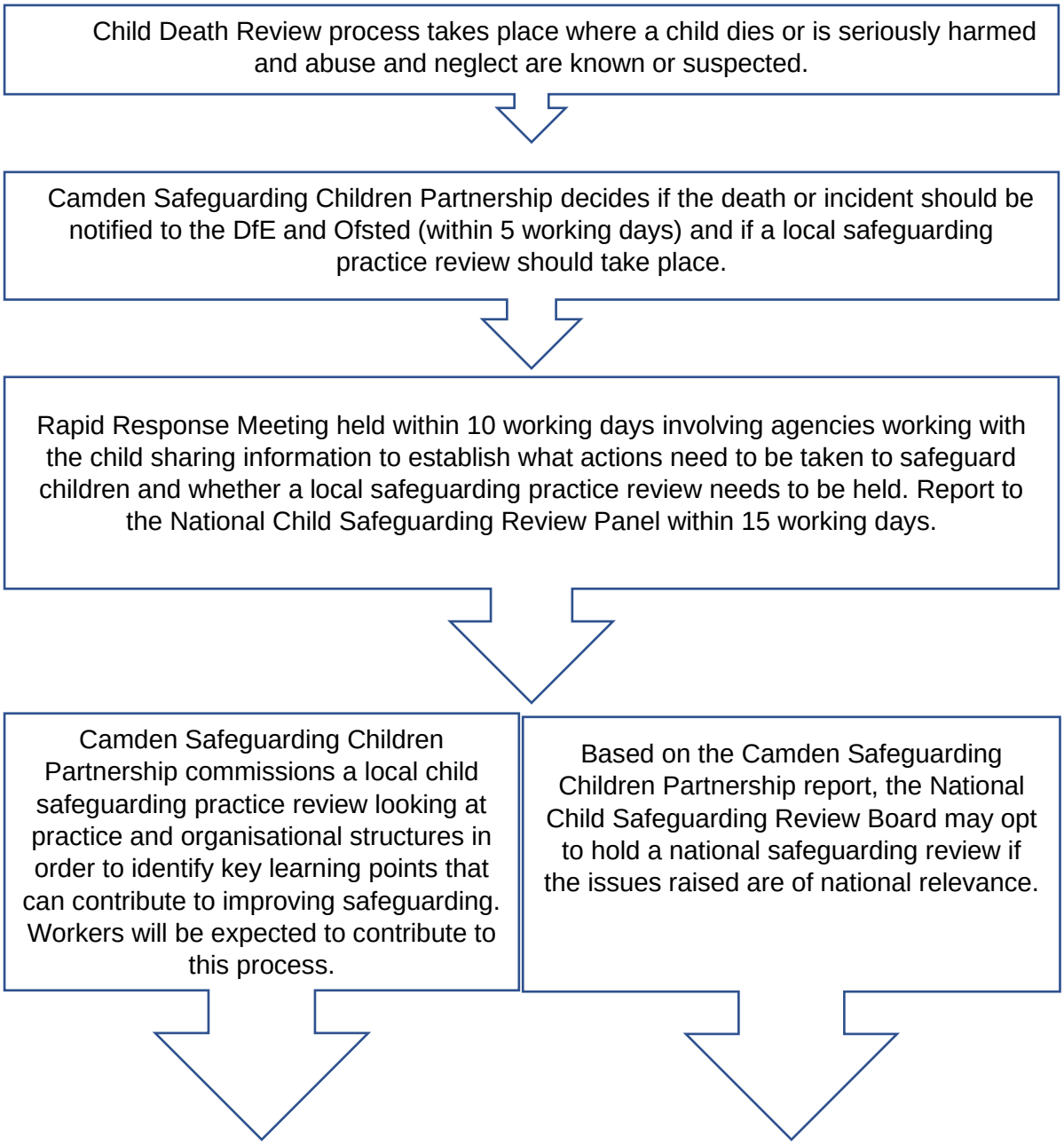
The following is the procedure for reporting and escalating serious incidents to senior management. A serious incident is defined as the death or near death of a child in the borough and the procedures apply whether or not the child is known to CFHS.

This process should happen as soon as information is known and phone used, with follow up emails.

The process should be complete within 2 hours.



Appendix 2: Child safeguarding practice review process



Appendix 3: Child death review process