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The Joint Agency Response (JAR) to unexpected Child deaths during the COVID-19 Pandemic: Guidance for Professionals.

Produced by a multi-Agency working group convened by the National Child Mortality Database management team.

Introduction

During Pandemic COVID the central aims of the Joint Agency Response (JAR) still apply although how these are enacted may need to change depending on circumstances.

The circumstance in which a JAR is required are unchanged, and are set out in Appendix 1 to this document

The absolute priority at all times must be the safety of staff, families and the public.

While COVID-19 will significantly affect the ability of services to react to sudden unexpected child deaths, it should be noted that whilst COVID-19 is not expected to cause significant numbers of child deaths, social isolation may lead to increased risk of child abuse and of self-harm. Children living in socially challenging circumstances may be at higher risk.

The aims of the JAR are:

- a) establish, as far as is possible, the cause or causes of the child's death
- b) identify any potential contributory or modifiable factors
- c) provide ongoing support to the family
- d) ensure that all statutory obligations are met
- e) learn lessons in order to reduce the risks of future deaths

See Appendix 1 for more information.

Issue of a Medical Certificate of the Cause of death (MCCD)

The chief Coroner has issued new guidance on completing a MCCD and death registration during the Covid-19 emergency (see Appendix 2).

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The new regulations are summarised below:

If a death is sudden but the attending doctor is confident that the death has arisen from a known, natural disease or condition, the doctor may write a Medical Certificate of the Cause of Death (MCCD).

There is no requirement for the doctor to have seen the body after death or to have attended the deceased within 28 days (note this timescale is increased compared to previous regulations).

If the doctor has not seen the body, and no doctor saw the deceased within 28 days of death the Registrar will refer the death to the coroner when the MCCD is presented to register the death (see Appendix 2)

If a MCCD can be written there is no need for the doctor to report the death to the coroner or commence a JAR.

If in any doubt the doctor should always discuss this with the coroner.

If at any stage in the JAR process, suspicious circumstances are identified, a criminal investigation will commence under the direction and guidance of a Lead Police Investigator. The Lead Police Investigator will refer to this guidance and seek, as far as possible, to accommodate its principles within the investigative strategy.

During the COVID-19 pandemic certain changes will need to be adopted in the management of child deaths requiring a JAR.

The aims of the JAR remain the same with two important additions to ensure the safety of all staff, parents, other family members and the public, and to identify lessons to be learned, especially the possible consequences of the strictly controlled and limited conditions in which families are living in the current pandemic.

To ensure these principles are followed, staff should follow national and local guidance on the use of Personal Protective Equipment (PPE), maintain social distancing principles as far as possible, and minimise the number of staff members involved in the care of the child and family.

Immediate Actions: if a child is found collapsed and unresponsive

Commence resuscitation and Transfer to hospital.

If resuscitation is in progress, the child and parents should be taken immediately to the nearest hospital with emergency paediatric facilities that is receiving emergency admissions.

The policy of which local hospitals are accepting emergency paediatric admissions may be different to normal during the Coronavirus pandemic

Some children's hospitals may be taking children of an older age than was previously the case.

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Resuscitation should be continued in line with local guidance unless and until life has been confirmed to be extinct by an appropriately qualified person.

Agencies must keep the deployment of staff to the hospital to the ***minimum number necessary***.

If death is confirmed:

A Child Death notification should be sent to the local CDOP as soon as possible.

(do not wait for full information to be available: this is of special importance during the Covid pandemic)

A Joint Agency Response should be initiated as per local guidance including discussion with the Coroner as appropriate but may involve predominantly telephone communications or video conferencing.

There must be communication between police, healthcare professionals (including First Responders) and Children's Social Care, plus other agencies (e.g. Fire and Rescue) when appropriate.

A careful, detailed history must be taken from the parents or carers by an experienced paediatrician, accompanied whenever appropriate and possible by a police officer (maintaining the principles of social distancing).

After discussion with the Lead Police investigator, parents may be offered the opportunity to hold their child following death if facilities are available and they wish to do so.

If the history raises the possibility of Covid-19 in the child, family member or other resident in the home then adopt strict protective measure as per local guidance.

The child should have a head to toe physical examination by a senior paediatrician or other appropriately trained health professional such as a SUDC Nurse, accompanied when possible and appropriate by a police officer trained in safeguarding children with appropriate use of PPE by all professionals.

Photography of any apparent lesions by the police if conducted must be in keeping with locally adopted policies on prevention of infection.

Routine ("Kennedy") samples (as agreed with the local Coroner) including an airway and rectal swab for Coronavirus should be taken, with appropriate use of PPE.

The results of the viral swabs will determine where and with what precautions the postmortem will take place.

A skeletal survey should be obtained as soon as possible, for children aged less than 2 years, subject to local arrangements

Transfer to mortuary

If the child is declared dead prior to transfer to hospital, it may not be appropriate to transfer the child to the Emergency Department if there are excessive clinical pressures in the department.

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It remains very important that these child deaths still receive a JAR.

Local alternative arrangements should be agreed in advance by all agencies with coroners.

Alternative plans could involve deceased children being admitted directly to mortuaries at children's hospitals which are less likely to be overwhelmed with COVID-19 patients.

Mortuary spaces in Children's Hospitals may need to be reserved for Sudden Unexpected Deaths in Childhood (SUDIC).

*SUDIC children **should not** be taken to emergency overflow mortuaries for COVID-19 victims, as a post-mortem examination remains an essential investigation for such children, and whenever possible families should be permitted to view their child.*

SUDIC children transferred directly to mortuaries will still require a detailed medical and social history to be taken from parents or carers, a detailed physical examination, agreed ("Kennedy") samples (including COVID swabs) to be taken, and a skeletal survey, as for children brought in to the Emergency Department, subject to local arrangements

Hospitals receiving such children should identify a suitable place for such interviews to take place – preferably a place where families can spend some time with their child e.g. a bereavement suite.

Many areas do not have 24-hour provision of health care professional support outside of hospital, so it is unlikely that health care professionals will be able to fulfil these tasks when children are not brought to Emergency Departments.

Suggested solutions are below:

A medical history can be taken by the SUDIC health professional by telephone.

An initial external examination (preferably with video recording) looking specifically for evidence of injury or abuse may be undertaken in the home, ambulance or other specified place by an attending police officer (if possible one with child safeguarding training) and shared with the paediatrician and pathologist.

A detailed full physical examination should be undertaken as soon as possible by a senior paediatrician (accompanied whenever possible by a police officer).

The locally agreed ("Kennedy") samples (including Covid-19 viral swabs) should be taken as soon as possible. *If the postmortem is to be performed within 48 hours the "Kennedy" samples could be taken at postmortem but should not be delayed more than 24-48 hours.*

Coronavirus swabs (airway and rectal) must be taken as soon as possible, as the place and precautions to be used in the postmortem examination will depend on these results.

A blood culture should be taken as soon as possible as some organisms (notably meningococcus and pneumococcus) only survive a short time in blood after a child's death

Every effort should be made to complete the full range of investigations as soon as possible but this must not compromise the safety of staff and public and it is recognised that it might not be possible in some circumstances.

Skeletal surveys should be carried out as soon as possible in an appropriate radiology department with paediatric expertise.

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Joint home visits

The joint agency home visit remains a key element of the SUDIC response, and in the COVID-19 emergency conditions, joint agency home visits should take place unless this is assessed as being unsafe or not possible because of staffing constraints at the initial discussion between police and health professionals.

The need for a home visit should be discussed at the first joint agency discussion, and where there is no apparent safety issue in conducting such a visit this should be carried out by the most appropriate agency or agencies with appropriate personal protective equipment and forensic precautions. Such examinations of the home / scene of death should be video recorded whenever possible

It is important to minimise the number of people from any of the agencies who enter the home, in order to protect both staff and family members.

If suspicious circumstances are present, then the strategy for examining the home address will be led by the Police Lead Investigator, including implementation of an appropriate forensic strategy.

If the home is to be treated as a potential crime scene the police must ensure appropriate arrangements are made for safe and suitable temporary housing for household members

If a probable medical explanation or cause of death exists, then this will reduce the likely necessity for a home visit to take place.

If the visit is necessary, Personal Protective Equipment (PPE) according to current applicable guidance will be needed for the duration of the visit. Police Officers should utilise the support of officers with specialist forensic protective equipment if needed.

Professionals must only enter the home if they have suitable personal protective equipment

If a decision is made by professionals not to complete a home visit, then the officers holding the scene must be requested to use body worn video to record the home scene.

See:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877599/T2 Recommended PPE for primary outpatient and community care by setting poster .pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877599/T2_Recommended_PPE_for_primary_outpatient_and_community_care_by_setting_poster.pdf)

Initial and final SUDIC meetings

These meetings should be arranged as teleconferences or video conferences for the foreseeable future.

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Where a home visit has not taken place because of concerns around COVID-19, the initial SUDIC meeting should be arranged as soon as possible, so agencies can share information, and safeguarding arrangements considered for any remaining siblings.

Follow-up meetings with families

Follow-up home visits should not take place in person, but families should still receive support and get the chance to discuss post-mortem results, future pregnancies, and potential issues for siblings. The CDR teams should remain in telephone contact with families; and they should be offered telephone follow-up appointments with paediatricians when needed.

Families should also be given details of organisations that may be able to offer telephone support (e.g. the Lullaby Trust).

Families are likely to struggle even more than usual with unexpected child deaths given the need for social isolation and distancing. CDR teams should proactively offer telephone support to parents.

A final face to face meeting with the paediatrician should be offered to families as soon as this is permitted under national or local regulations.

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Appendix 1

(Child Death Review: Statutory and Operational Guidance (England)
Cabinet Office. September 2018)

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf]

Joint Agency Response

A coordinated multi-agency response (on-call health professional, police investigator, duty social worker), should be triggered if a child's death:

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

The full process for a Joint Agency Response is set out in the SUDI/C Guidelines.

[<https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf>]

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Appendix 2.

Advice from the Office of the Chief Coroner

SUMMARY OF THE CORONAVIRUS ACT 2020

PROVISIONS RELEVANT TO CORONERS

These are the essential things to know on MCCDs and cremation following implementation of relevant provisions in the Coronavirus Act 2020.¹

This is the Chief Coroner's Office's assessment of the legislative position. Coroners should also consult the underlying statutory provisions and any detailed published guidance from other organisations e.g. GRO, MOJ etc because there are more aspects of the new statutory position (and the practice that will accompany it) not dealt with here.

MCCDs

Signing and attendance are effectively decoupled, but with safeguards. Any registered medical practitioner can sign an MCCD, even if the deceased was not attended during their last illness and not seen after death, provided that they are able to state the cause of death to the best of their knowledge and belief.² Once that MCCD reaches the registrar there are two possibilities depending on whether the deceased was seen before or after death.

First, if a medical practitioner (who does not have to be the same medical practitioner who signed the MCCD) attended the deceased within 28 days before death (a new, longer timescale)³ or after death, then the registrar can register the death in the normal way.

Second, if there was no attendance either within 28 days before death or after death, then the registrar would need to refer that to the coroner.⁴ This is a safeguard parliament put in place to ensure that MCCDs are not issued without any recent medical practitioner attendance prior to or after death or without any other form of oversight (in this case, by a coroner).

The coroner could cover the second scenario with a Form 100A if they decided it was appropriate to do so. In practice, it may be that the signing medical practitioner and the coroner are in communication before the MCCD reaches the registrar. Either way the outcome would be the same upon issue of the 100A.

The General Register Office position is that attendance before death can be visual (i.e. in person) or by video (e.g. Skype), but cannot be audio (i.e. telephone) only. Attendance after death must be in person.

Clearly, some form of attendance would be ideal since it will reduce natural cause referrals to the coroner.

Medical practitioners' duty to notify coroners

The Notification of Deaths Regulations 2019 provide that a registered medical practitioner must notify the coroner where:

- it is reasonably believed that there is no attending medical practitioner required to sign the MCCD (Reg 3(1)(e)); or
- it is reasonably believed that the attending medical practitioner required to sign the MCCD is not available to do so within a reasonable time of the person's death (Reg 3(1)(f)).

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The emergency legislation disapplies this requirement because, as set out above, the medical practitioner who signs the MCCD does not need to have attended. The duty on a medical practitioner to notify the coroner only applies during the emergency period where it is reasonably believed that there is no other medical practitioner who may sign the MCCD (or that such a medical practitioner is not available within a reasonable time of the person's death to do so).⁵

Cremation

The requirement for a confirmatory certificate (Cremation Form 5) is suspended. There is only a requirement for one medical certificate (Cremation Form 4).⁶

Any medical practitioner can complete Cremation Form 4. They do not have to have seen the deceased. However, a medical practitioner (not necessarily the medical practitioner who signs the Cremation Form 4)⁷ should have attended the deceased (including³ visual/video/skype consultation) within 28 days before death or *viewed* the body after death. 'Viewing' here means in person. However, the crematorium medical referee may accept a Cremation Form 4 where the deceased has not been seen within 28 days before death or after death but where the death has been registered with an MCCD supported by a Form 100A.

It is open to the medical referee to consult the coroner's office, should he so wish, before authorising the cremation.

COVID-19 as a notifiable death and jury inquests

COVID-19 has been listed as a notifiable death under the Health Protection (Notification) Regulations 2010 which means it is notifiable to Public Health England. Where the coroner decides to open an inquest, section 30 of the Coronavirus Act 2020 removes the requirement for an inquest to be held with a jury if the coroner has reason to suspect death was caused by COVID-19.

It is worth restating here that although COVID-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010 that does not mean a report of death to a coroner is required by virtue of its notifiable status (the notification is to Public Health England), and there will often be no reason for deaths caused by this disease to be referred to a coroner.

Exercise of powers in the Act

The Coronavirus Act 2020 is not retrospective. It received Royal Assent on 25 March 2020. The provisions on death registration came into force on 26 March 2020.⁸

⁸ <http://www.legislation.gov.uk/uksi/2020/361/introduction/made>

⁹ See Sched 13, Part 1, para 4(1) Coronavirus Act. This 'future-proofs' the MCCD provisions in case the prospective provisions in para 14, Sched 21 Coroners and Justice Act 2009 are commenced during the two year life of the Coronavirus Act.

The provisions in the Act regarding MCCDs will remain effective during the life of the Act.⁹

**CHIEF CORONER'S OFFICE
JUDICIAL OFFICE
30 MARCH 2020**

References.

- 1) <http://www.legislation.gov.uk/ukpga/2020/7/contents/enacted>
- 2) If the deceased was attended by a registered medical practitioner, if that practitioner is unable to sign the MCCD or it is impractical for that practitioner to do so, another medical practitioner can sign (Schedule 13, Part 1, paragraph 4(2)(a) Coronavirus Act 2020).

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3 The Registration of Births and Deaths Regulations 1987 (SI 1987/2088) Reg 41(b)(ii) as amended by Sched 13, Part 1, para (6)(3)(b) Coronavirus Act 2020.

4 Sched 13, Part 1, para 4(6) Coronavirus Act 2020 disapplies the normal duty on the registrar to report a death to the coroner when the deceased was not attended by a medical practitioner during their last illness (Reg 41(1)(a) of the 1987 Regulations). However, Reg 41(1)(b)(ii) (as modified by the Coronavirus Act) remains in force, i.e. that if the deceased was not seen by a medical practitioner either after death or within 28 days before death the registrar must refer the death to the coroner.

5 Sched 13, Part 1, para 7(1) Coronavirus Act 2020.

6 Section 19 Coronavirus Act 2020.

7 Reg 41(b)(ii) of the 1987 Regulations, as amended by s18 and Sched 13, Part 1, para 6(3) Coronavirus Act.