

# UNEXPECTED DEATH OF A CHILD POLICY

The unexpected death of a child at a Service is a traumatic event and the impact on Educators, children and families can cause emotional turmoil, which can overwhelm usual coping skills. A policy providing comprehensive procedures is therefore crucial to ensure a coordinated response, and the timely notification required to the regulatory authorities.

As a result of the suddenness of such an event, well-trained and experienced staff can experience strong emotions and traumatic stress responses. The role of our OSHC Service is to help restore a sense of safety for children, Educators, and families as soon as possible following a traumatic event.

## NATIONAL QUALITY STANDARD (NQS)

### QUALITY AREA 2: CHILDREN'S HEALTH AND SAFETY

<b>2.2.2 Incident and emergency management</b>	Plans to effectively manage incidents and emergencies are developed in consultation with relevant authorities, practiced and implemented.
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### EDUCATION AND CARE SERVICES NATIONAL REGULATIONS

<b>12</b>	Meaning of serious incident
<b>85</b>	Incident, injury, trauma and illness policies and procedures
<b>176</b>	Time to notify certain information to Regulatory Authority

## PURPOSE

Our OSHC Service will ensure that Management and Educators follow the procedures and principles within this policy and that immediate and appropriate action is taken to notify relevant authorities in the event of the death of a child whilst at the Service. There are a number of legal requirements to adhere to in the tragic event of the death of a child at a Service as outlined below.

## SCOPE

This policy applies to management and staff of the OSHC Service.

## **IMPLEMENTATION**

### **SERIOUS INCIDENTS**

Regulation 12 defines a serious incident involving the death of a child as:

- (a) The death of a child –
  - I. while that child is being educated and cared for by an education and care service, or
  - II. following an incident occurring while that child was being educated and cared for by an education and care service;

### **NOTIFICATION OF A SERIOUS INCIDENT**

Under the National Law and Regulations (Section 174(2) (a) and Regulation 176 (2) (a)), the approved provider must notify the regulatory authorities within 24 hours of any serious incidents. This must be done by logging into the National Quality Agenda IT System (NQA IT System).

### **KEEPING CHILDREN'S RECORDS**

In the event of the death of a child whilst being cared for at the Service, records must be kept for 7 years from the date of the child's death.

### **INITIAL ACTION AND IMPLEMENTATION OF POLICY**

Management and Educators will ensure that immediate and appropriate action is taken in the event of the death of a child whilst at the Service by following and implementing the following procedures:

1. Assess the situation as per service and First Aid procedures for any immediate danger to other children and/or staff.
2. Provide immediate First Aid and/or CPR in accordance with current First Aid training.
3. Call an Ambulance immediately.
4. Management/Responsible person will call the parents/guardian of the child and arrange to meet at the hospital.
5. The Service must not advise parents of the death of their child: Medical staff will advise families of the situation.
6. Notify Regulatory Authorities including the Police Department.
7. Notify the Approved Provider (if not at the service).
8. The Responsible person will complete in detail the Service's *Incident, injury, trauma and illness* form (in addition to notifying ACECQA via the NQA IT System).

9. The Approved provider will log the incident on the NQA TI System, attaching incident form and evidence.
10. Management/Approved provider will contact the insurance company.

Management will also ensure that parents, families, children and educators will receive adequate and appropriate post-incident support.

Additionally, management will:

- Demonstrate sensitivity, open mindedness and a balanced approach.
- Recognise and support cultural needs.
- Ensure all evidence is preserved.
- Maintain accurate and detailed record keeping.
- Contact their legal representative for support and direction.
- Establish protocols for staff and Educators to discuss the traumatic event.
- Advise staff of social media protocol for the event.
- Provide professional and sensitive communication with families of the Service.
- Engage the services of health care professionals (counselling and support for staff).
- Cooperate on an ongoing basis with inter-agencies involved in the investigation.

### **CARING FOR THE WELLBEING OF EDUCATORS, CHILDREN, AND FAMILIES**

Our Service will engage health professionals who may include child and family counsellors and psychologists to support our Educators to be sensitive and mindful of the impact such an event has had on all stakeholders. With professional guidance and support, we will encourage children to express their emotions and feelings and implement strategies to assist and guide children's process of grieving and re-engage children in learning.

Our Service will seek advice and support from health professionals to provide appropriate materials to send home to families to assist in understanding the effects of trauma on children and possible changes in behaviour following the unexpected death of a child in our Service.

### **SOURCE:**

- Australian Centre for Grief and Bereavement: <http://www.grief.org.au>

- Australian Child & Adolescent Trauma, Loss & Grief Network:  
[http://earlytraumagrief.anu.edu.au/files/ACATLGN\\_grief\\_and\\_loss.pdf](http://earlytraumagrief.anu.edu.au/files/ACATLGN_grief_and_loss.pdf)
- Education and Care Services National Amendment Regulations. (2017).
- Education and Care National Regulations. (2011).
- Karen Kearns. (2017). *The Business of Childcare* (4<sup>th</sup> Ed.).
- Guide to the National Quality Standard. (2017).
- *Occupational Health and Safety Act 2004*.
- What Do We Tell the Children When Someone Dies?  
[http://www.adac.org.au/siteF/resources/l\\_children\\_gt.pdf](http://www.adac.org.au/siteF/resources/l_children_gt.pdf)
- *Work Health and Safety Act 2011*.

## REVIEW

POLICY REVIEWED	DECEMBER 2018	NEXT REVIEW DATE	DECEMBER 2019
MODIFICATIONS	New policy drafted		