London
Rapid Response
Procedure

London Safeguarding Children Board
59½ Southwark Street
London SE1 0AL

65Hwww.londonscb.gov.uk

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Acknowledgement

The London Safeguarding Children Board thanks Harrow Safeguarding Children Board and the Metropolitan Police for providing the basis for this procedure.

1. Introduction

1.1 This Procedure sets a minimum standard for a Rapid Response service for unexplained deaths in infancy and childhood as outlined in chapter 7 of the Government guidance *Working Together to Safeguard Children (DCSF, 2006)*.

1.2 This Procedure should be followed when:

- A decision has been made that a death of a child is unexpected; or
- There is a lack of clarity about whether a death of a child is unexpected.

1.3 The aim of the Procedure is to ensure that there is overall uniformity across London in the multi-agency response to child deaths, and that the response is safe, consistent and sensitive to those concerned, including ensuring that bereaved parents and siblings receive similar approaches across London.

1.4 The Procedure will enable the capturing of immediate information about unexpected child deaths. In addition to assisting to support the bereaved family, this ensures opportunities for information gathering are not lost. Collective information on such cases will inform Local Safeguarding Children Board Child Death Overview Panels (CDOP) and consequently the learning about trends and patterns in child deaths to generate and influence future prevention strategies.

1.5 This is a multi-agency Procedure and is not agency or discipline specific. It outlines what needs to be achieved and gives broad suggestions about the roles of agencies. It does not replace existing internal agency or professional procedures, although it may generate a review of those procedures to ensure consistency across London.

2. Terms and remit

First professional on the scene

2.1 If the first professionals on the scene are not medical professionals, then they must obtain urgent medical assistance as the first priority. The ambulance service or GP / doctor should not assume death. They must:

- Initiate immediate resuscitation unless clearly inappropriate. Resuscitation once commenced should be continued according to the *UK Resuscitation Guidelines (2005)* until an experienced doctor (usually the consultant paediatrician on call) has made a decision that it is appropriate to stop;
- Notify the police if they are not already present. Once the death has been confirmed as unexpected (see definition in section 2.5), London Ambulance Service crew attending the death should contact Ambulance Communications Centre, who in turn will inform police (ambulance staff should follow the *Joint Royal Colleges Ambulance Liaison Committee Guidelines* and the *London Ambulance Service Child Protection Procedures*);
- Arrange for the body to go to an accident and emergency department (rather than a mortuary) by ambulance, unless the circumstances of the death require the body to remain at the scene for forensic examination;
- Prior to arrival at the accident and emergency department, provide relevant information and history to accident and emergency staff.

Rapid Response service

2.2 Rapid response describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

2.3 The purpose of Rapid Response is to ensure that the appropriate agencies are engaged 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 the types of enquiries that relate to the current responsibilities of each organisation when a child dies unexpectedly;
- Collate information in a standard format (see the *Child death information gathering and evaluation* booklet in appendix 4);
- Engage appropriately post death, maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities to the family, to ensure that they are appropriately informed.

2.4 Rapid response begins at the point of death and ends with the completed report to the Child Death Overview Panel following the case discussion meeting when the final results of the post mortem has been completed and can be shared.

An unexpected death

2.5 This Procedure applies when a chid dies unexpectedly (birth up to 18th birthday, excluding babies stillborn). This includes traffic accidents, suicides and murders.

2.6 An unexpected death is defined as the death of a child 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.

2.7 This Procedure does not apply to stillbirths.

3. Policy context

3.1 This Rapid Response Procedure must be seen within the context of the overall responsibilities of Local Safeguarding Children Boards to all child deaths, as outlined in chapter 7 of *Working Together to Safeguard Children (DCSF, 2006)*.

3.2 The Local Safeguarding Children Board will receive notifications of all deaths, expected and unexpected, and the child death notification form will be used (see Notification proforma in appendix 1). The Child Death Overview Panel will review all deaths (see the *London Child Death Overview Panels Procedure (LSCB, 2008)*.

3.3 Unexpected deaths will require a Rapid Response service, which will co-ordinate the detailed information required by the Child Death Overview Panel. In short, where deaths are unexpected, Rapid Response will be a significant phase in the management of the Local Safeguarding Children Board response to child deaths.

4. Single point of contact

4.1 Each Child Death Overview Panel must nominate a single point of contact (SPOC), available 24 hours, to be informed of all child deaths and to assist in initiating the multi-agency Rapid Response service.

4.2 The details of each borough's SPOC must be reported to the London Safeguarding Children Board to enable a list to be kept up to date on the London Safeguarding Children Board website www.londonscb.gov.uk.

4.3 It will be a core function of the Police Public Protection desks to be the single point of contact for the police, and to inform the Child Death Overview Panel SPOC of all deaths in their area.

5. Designated paediatrician for unexpected deaths in childhood

5.1 This role is described in *Working Together to Safeguard Children*, chapter 7, paragraph 7.18 and involves:

- Leading the co-ordination of multi-agency activity and information sharing throughout the rapid response process;
- Ensuring all agencies are notified and actions are agreed;
- Completing the initial notification form (see Notification proforma in appendix 1);
- Co-ordinating a case discussion or meeting within 5-7 days of the death;
- Co-ordinating a formal case discussion meeting 8-12 weeks following the death; and
- Ensuring that a full and accurate report is provided to the Local Safeguarding Children Board's Child Death Overview Panel (using the child death information gathering and evaluation booklet, and additional papers as appropriate).

5.2 The designated paediatrician responsible for unexpected deaths in childhood is responsible for making the decision about whether a death is unexpected.

5.3 All primary care trusts will need to make arrangements to ensure these roles are created and supported throughout London. This will involve accurate needs assessment and commissioning plans in collaboration with Local Safeguarding Children Boards and children's trust arrangements.

6. Issues for consideration in relation to the Rapid Response process

6.1 The Rapid Response timeline (involving three phases) is described in section 7 below. Within the three phases there are seven key strands for all agencies to consider when a child dies unexpectedly (see Issues for consideration in relation to the Rapid Response process in appendix 2).

6.2 The key strands must be managed and co-ordinated simultaneously, achieved through agreed leadership and collaboration. Each strand will have a subset of elements for each professional group and agency to consider, and these are not referred to in this procedure. All strands will be managed and co-ordinated to minimise confusion, and ensure consistent and high level support to bereaved families.

Care of the bereaved family

6.3 The death of a child will be a traumatic loss for a family, the more so if the death was unexpected. Bereaved family members, parents and children, may need help to cope in four areas[1]:

[1] Colin Murray Parkes OBE, MD, FRCPsych. Life President of *Cruse Bereavement Care* with the assistance of the Staff of Cruse.

- The trauma – unexpected losses, particularly if the parent/sibling was not present or able to hold or touch the lost child, are difficult to make real.
- Grieving – numbness as protection from over-whelming mental pain may be so pronounced that the family member cannot think clearly, become confused, loses their bearings, and/or may be unable to express feelings of any kind

  Grief can get stuck in self-blame, this is most likely to arise if it is a child who has died.
- Anger and self-reproach – anger is a very natural reaction to outrageous loss, particularly if it was caused by human agency. It may be directed appropriately against the perpetrators of the trauma or inappropriately against all authorities or against the people nearest to hand.
- Change – when disaster strikes, all in a moment the world becomes a dangerous place because the family's assumptions about the world cannot be taken for granted any more.

See Services available from Cruse Bereavement Care in appendix 5.

6.4 The seven key strands are:

1) Care of the bereaved family:

Ensuring at every phase that the needs of the bereaved family are considered. This includes the welfare and protection of remaining siblings, spiritual needs and possible involvement of the extended family (see section 6.3 above).

2) Deciding on response:

Deciding on whether the death is unexpected and whether to implement the rapid response procedure. The designated paediatrician responsible for unexpected deaths in childhood is responsible for making the decision about whether a death is unexpected.

3) Notification to the Single Point of Contact (SPOC):

The SPOC will be notified of all child deaths by the attending paediatrician, using the notification form (see Notification proforma in appendix 1).

Notification must be immediate in order for the rapid response to commence. The attending paediatrician (or delegated senior health professional) will make this notification and make arrangements for multi-agency co-ordination and information sharing. This will remain the responsibility of the attending paediatrician until s/he is able to hand over to the designated paediatrician for unexpected deaths in childhood.

The police and LA children's social care (through out-of-hours emergency duty teams (EDTs) if necessary) must be notified by the attending paediatrician immediately.

The coroner and Director of Public Health must be notified by the SPOC on the next working day.

4) Child protection:

Emerging information giving rise to child protection concerns about remaining siblings and/or other children in the household or peer group will require formal referral to LA children's social care in line with *section 6. Referral and assessment*, in the *London Child Protection Procedures (LSCB, 2007)*. See also *section 5. Children in specific circumstances, London Child Protection Procedures (LSCB, 2007)*.

See also section 8.2.3 below.

5) Serious case review:

All agencies need to be mindful of any emerging information giving rise to the need for the LSCB to consider conducting a serious case review in line with *section 19. Serious case reviews* of the *London Child Protection Procedures (LSCB, 2007)*[2]. A review of this nature would be conducted using chapter 8 of *Working Together* and will operate simultaneously to the rapid response procedure.

The decision to undertake a serious case review must be taken by the Chair of the LSCB where the child normally resides.

6) Media issues:

All Local Safeguarding Children Boards should have a process for managing media interest. Staff must be enabled to proceed with their functions without intrusion and the family provided with privacy.

Media attention and enquiries will be managed by the Local Safeguarding Children Board in collaboration with the Metropolitan Police press office.

7) Support to staff:

Child deaths will have varying degrees of impact on staff. Agencies need to be aware that clear procedures, effective communication and leadership will provide staff with confidence and enable them to respond appropriately to families. Staff may respond to the emotions involved and agencies should have arrangements in place to manage this.

6.4 All of these strands will need management throughout the process of Rapid Response. Deaths involving child protection concerns, and those needing a serious case review and/or attracting media attention will be especially challenging.

6.5 LSCBs may choose to designate particular professionals to be standing members of a team because of their roles and particular expertise. The professionals who come together as a team will carry out their normal functions, i.e. as a paediatrician, GP, nurse, health visitor, midwife, mental health professional, social worker, probation or police officer, in response to the unexpected death of a child in accordance with this guidance.

[2] *Section 19. Serious case reviews*, of the *London Child Protection Procedures (LSCB, 2007)* is in accordance with *Chapter 8* of government guidance *Working Together to Safeguard Children (DCSF, 2006)*.

Local Safeguarding Children Board responsibilities

6.6 The strands should be managed by Local Safeguarding Children Boards at the same time as rapid response procedures are activated and in collaboration with the designated paediatrician responsible for deaths in childhood. See section 5. Designated paediatrician for unexpected deaths in childhood above.

7. Rapid response timeline

7.1 The Rapid Response timeline involves three phases:

- Phase one (usually 0-5 days): the management of information sharing from the point at which the child's death becomes known to any agency until the initial results of the post-mortem have been completed;
- Phase two (usually 5-7 days): the management of information sharing once the initial post mortem results are available; and
- Phase three (usually 8-12 weeks): the management of information sharing through the case discussion meeting when the final post-mortem report is available.

See also Rapid Response Flowchart in appendix 3.

7.2 It is important that all agencies are clear that the rapid response process is multi-dimensional, the information flow is variable, and there is a need to be aware of the issues set out in section 6 Issues for consideration in relation to the Rapid Response process, and the number of different processes that can occur at the same time.

7.3 The remainder of this procedure will focus on these three phases. For clarity, section 8 will refer only to the critical elements of rapid response and not to all of the strands described in section 6 above, and referred to in Issues for consideration in relation to the rapid response process in appendix 2.

8. The three phases of Rapid Response

8.1 Phase I: usually 0 – 5 days

Immediate response:

In hospital

8.1.1 Babies who die suddenly and unexpectedly at home should be taken to an accident and emergency department (A&E) rather than a mortuary, and resuscitation should always be initiated unless clearly inappropriate (see section 2.1. First professional on the scene).

8.1.2 Older children should also be taken to A&E unless this is inappropriate (e.g. if the circumstances of the death require the child's body to remain at the scene for forensic examination).

8.1.3 As soon as practicable (i.e. as a response to an emergency) after arrival at a hospital, the baby or child should be examined by the consultant paediatrician or delegated senior paediatric clinician on call. In some cases, this examination might be undertaken jointly with a consultant in emergency medicine, or for some children over 16 years of age, the consultant in emergency medicine may be more appropriate than a paediatrician. A detailed and careful history of events leading up to and following the discovery of the child's collapse should be taken from the parents / carers. The information should be collated using the *Child death information gathering and evaluation booklet* in appendix 4.

8.1.4 Where the cause of death or factors contributing to it are uncertain, investigative samples should be taken immediately on arrival and after the death is confirmed. These need to be agreed in advance with the coroner and should include the standard set for *Sudden Unexpected Death in Infancy (Royal College of Pathologists and Royal College of Paediatrics and Child Health, 2004)*[3] and standards set for other types of death presentation as they are developed. Consideration should always be given to undertaking a full skeletal survey, and if this is appropriate it should be done prior to autopsy.

8.1.5 When the baby or child is pronounced dead, the consultant clinician or delegated senior paediatric clinician for children under 16 should inform the parents, having first reviewed all the available information. S/he should explain future police and coronial involvement, including the coroner's authority to order a post-mortem examination. This may involve taking particular tissue blocks and slides to ascertain the cause of death. The consultant paediatrician should obtain consent from those with parental responsibility for the child, as this is required for tissue to be retained beyond the period required by the coroner.

8.1.6 The consultant paediatrician who has seen the child should inform the designated paediatrician for unexpected deaths in childhood immediately after the coroner is informed.

8.1.7 The same processes will apply to a child who is admitted to a hospital ward and subsequently dies unexpectedly in hospital.

In the community

8.1.8 Where a child is not taken immediately to A&E, the professional confirming the fact of death should inform the designated paediatrician with responsibility for unexpected deaths in childhood at the same time as the coroner is informed.

8.1.9 The police will be involved and may decide that it is not appropriate to move the child's body. This may typically occur if there are clear signs which give rise to suspicion. In most cases however, it is expected that the child's body will already have been held or moved by the carer and, therefore, removal to A&E will not normally jeopardise an investigation.

[3] http://www.rcpath.org/resources/pdf/SUDI%20report%20for%20web.pdf

Immediate notification

8.1.10 In all cases, the attending consultant paediatrician must see the family and explain the police and coronial involvement, and immediately notify the designated paediatrician responsible for unexpected deaths in childhood (using the Notification proforma in appendix 1).

8.1.11 The designated paediatrician for unexpected deaths in childhood is responsible for co-ordinating the multi-agency response, and should ensure that the following are notified:

- The coroner;
- The police;
- LA children's social care;

And, in a timely manner, will notify:

- The Child Death Overview Panel (using the *Child death information gathering and evaluation* booklet, in appendix 4)
- The Director of Public Health

Information sharing

8.1.12 The designated paediatrician for unexpected deaths in childhood must ensure that information is shared immediately with relevant agencies such as the police, health and LA children's social care to decide next steps, and that all strands in Issues for consideration in relation to the rapid response process, appendix 2 are taken into account. This may or may not involve a meeting.

Potential visit to the place where the child died

8.1.13 A decision must be made about whether a visit to the place where the child died should take place within 24 hours when a child dies unexpectedly in a non-hospital setting. The professionals responsible for the decision are the investigating police officer and the designate paediatrician for unexpected deaths in childhood. A visit within 24 hours to the place where the child died should be considered for infants who die unexpectedly.

8.1.14 As well as deciding if the visit should take place, it should be decided how soon within the 24 hours it should take place, and who should attend. This will be matter for professional judgement and agreement.

8.1.15 The purpose of the home visit is to gather information which may provide immediate insight into the cause of death, or which may later prove significant to the coroner or to any criminal investigation. Bereaved parents are anxious to know the cause of their child's death and this visit provides them with reassurance that the enquiry is rigorous and high level.

8.1.16 At times it will not be appropriate to move the child's body, particularly where there are clear signs that lead to suspicion. Police will be involved in these cases and these decisions will be made after consideration by the police Senior Investigating Officer (SIO).In most cases, however, it is expected that the child's body will have already been held or moved by a carer, and therefore removal to A&E will not normally jeopardise the investigation.

8.2 Phase II: within 5 – 7days

8.2.1 A case discussion following the preliminary results of the post-mortem examination becoming available will take place. This will be arranged by the designated paediatrician for unexpected deaths in childhood and will involve the police officer and the pathologist. The coroner will be informed of the initial results as soon as possible. The *Child death information and evaluation* booklet in appendix 4, should be updated at this stage. A meeting may be necessary and all relevant health and LA children's social care professionals and relevant professionals from other agencies should be invited to attend.

8.2.2 The purpose of this case discussion / meeting will be to ensure that all agencies are informed and updated, that any concerns are identified and managed and that all are working together on each strands as and where relevant, and in accordance with fulfilling their duties.

8.2.3 If following the death or the initial post mortem emerging information gives rise to child protection concerns about remaining siblings and/or other children in the household or peer group, a s.47 strategy discussion will be required (and could be held within the same case discussion / meeting) to look at any action required to protect other children. This strategy discussion / meeting should be in line with *section 7. Child protection enquiries*, in the *London Child Protection Procedures (LSCB, 2007)*. See also section 6.3, point 4) child protection, above.

8.3 Phase III: within 8 – 12 weeks

8.3.1 A further case discussion meeting should be convened and chaired by the designated paediatrician for unexpected deaths in childhood following the final results of the post-mortem examination becoming available. This should involve those who knew the child and family and those involved in investigating the death - the GP, health visitors, school nurse, paediatrician/s, pathologist or pathologist report, police senior investigating officers, coroner or coroner's officer and, where relevant, social workers.

8.3.2 The purpose of the meeting is to share information to identify the cause of death and/or those factors that may have contributed to the death and then to plan the future care for the family. Potential lessons to be learned may also be identified at this stage. The outcome of this meeting will inform the inquest, if there is one.

8.3.3 The meeting should explicitly address the possibility of abuse or neglect as causes or contributory factors in the death, and the outcomes of this should be recorded.

8.3.4 The meeting should agree on how the parents will be informed about the outcome of the meeting and how they will be provided with on-going support.

8.3.5 The results of the post-mortem examination should be shared with parents. The designated paediatrician for unexpected deaths in childhood should arrange this. This sharing must be consistent with the requirements of the coroner and the police enquiries.

8.3.6 A record of the meeting and the completed *Child death information and evaluation* booklet in appendix 4, should be forwarded to the Child Death Overview Panel and the coroner.

Appendix 1: Notification to the designated paediatrician for unexpected deaths in childhood and the LSCB of a child's death

Working Together to Safeguard Children (DfES, 2006 - WT) chapter 7 sets out a statutory requirement for the Local Safeguarding Children Board to review the deaths of all children up to their 18th birthday.

Section 7.51 (WT) states that the LSCB should be informed of all deaths of children normally resident in the LSCB's geographical area. The designated paediatrician for unexpected deaths in childhood (or delegate) will usually do this and should be notified of all child deaths in the area or of children usually resident in the LSCB area but who die in another area.

Local agencies responding to a child's death as well as informing the coroner, if needed, should inform the designated paediatrician for unexpected deaths in childhood (or delegate) for the LSCB area using the attached proforma. Information can be conveyed in a confidential telephone conversation but there should be agreement during this call as to who will take responsibility for completing the attached written notification proforma. Where the information is passed by telephone it will be helpful for both parties to have a copy of the proforma in front of them while talking to assist the sharing of information.

The information should be treated in strictest confidence.

Designated paediatricians:

[insert name of Local] Safeguarding Children Board	Fax:	Tel:
[insert name of Local] Safeguarding Children Board	Fax:	Tel:
Etc.		

The written Notification proforma should be completed as fully as possible and sent the same day. For deaths which occur after 5pm, at weekends or on bank holidays, the written Notification proforma should be sent by 10am the next working day.

Parental consent is not required for this information to be passed to the designated paediatrician / Local Safeguarding Children Board. It should only be shared with those who need to know as governed by the Caldicott Principles, the *Data Protection Act* and *Working Together 2006*. Persons with parental responsibility *(Children Act 1989)* should be advised that the child's death will be subject to a review in order to learn any lessons tat may help to prevent future deaths of children. This must be handled sensitively. There is a LSCB leaflet available to assist parents and others with parental responsibility in understanding the review process and how they can contribute (see www.londonscb.gov.uk/child_death/. This would normally be done by the paediatrician confirming the child's death to the parents.

A death that is unexpected[4] may require a **rapid response** or a specific review of circumstances or an unexpected child death meeting as set out in the *London Child Protection Procedures section 12* [5]. It will be the responsibility of the designated paediatrician for unexpected deaths in childhood (or delegate) and senior police officer in the case to agree the process that such a response will take. This may involve LA children's social care or other agencies as needed.

[4] ' … defined as a death of a child (birth to 18 years, excluding babies stillborn) 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 which led to the death'. London Child protection Procedures 2007 Section 12.1.1

[5] ***London Child Protection Procedures*** – every agency must ensure that staff have access to a copy – they can also be accessed at www.londonscb.gov.uk/procedures

Initial notification of the death of a child – to be completed as fully as possible within the hour – DO NOT DELAY

1	Initial notification Unique Reference Number (e.g. KG/08/0001)		
2	Date / time of notification		
3	Name and title / role of caller		
4	Caller contact number		
5	First and other names of child		
6	Family name of child		
7	Date of birth of child		
8	Sex of child		
9	Ethnicity of the child		
10	Home address of child		
11	Postcode of child's home address		
12	Carer of child at time of death		
13	Name/s of persons with parental responsibility i.e. mother, father or other (state relationship)		
14	Other children in household or affected by the death (including children potentially at risk of harm)	Names (PRINT)	Ages / date of birth (if known)
15	Date and time of death		
16	Place / locality of death		
17	Contact number of place of death		
18	Summary description of the circumstances of the death		
19	Is this an unexpected death? i.e. not expected in the previous 24 hours	YES / NO	
20	GPs name		
21	Signature / name of the caller Sign and PRINT		
22	Date		

Please fax the form to the relevant LSCB Single Point of Contact. The fax should be marked STRICLY CONFIDENTIAL

See **www.londonscb.gov.uk** for contact details of the Single Point of Contact for each London LSCB.

Initial notification Unique Reference Number

The table contains identification codes used by the Territorial Police in the MPS for the 32 London Boroughs (You will see the corresponding letters on the shoulders of officers patrolling the local areas). In addition there is a suggested code for City of London that is not a Metropolitan Police area but for Safeguarding Children processes is aligned with Hackney LSCB. (This additional designation code may be required or not)

The suggested format for each Single Point of Contact to use from 1st April 2008 will be to use the code followed by the year and then a sequential number using four spaces. Thus the first report of a death of a child in Barking & Dagenham would be recorded as **KG/08/0001.**

Alphabetical Boroughs List of Codes

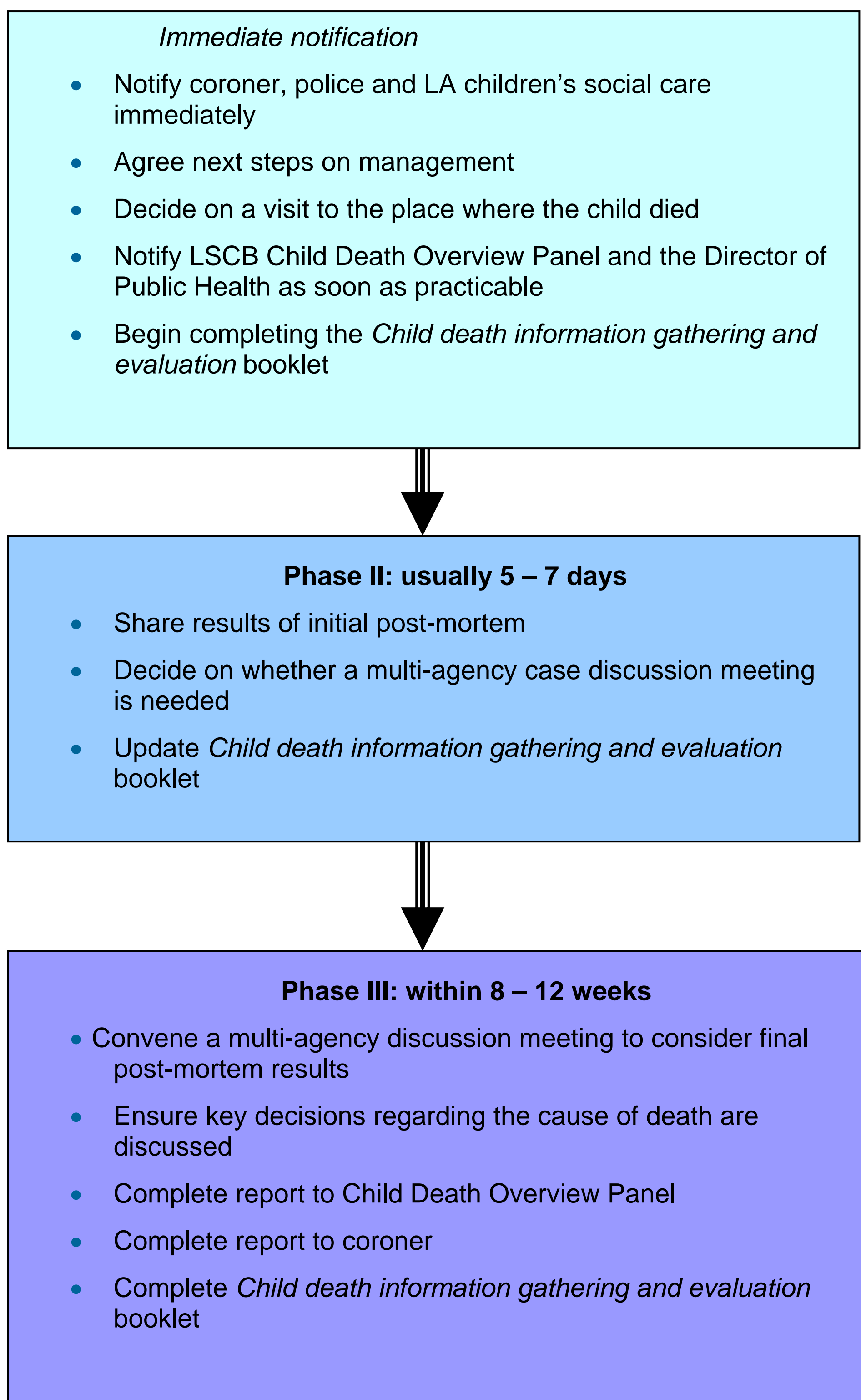
Borough	Code	Borough	Code
Barking & Dagenham	KG	Hounslow	TX
Barnet	SX	Islington	NI
Bexley	RY	Kensington & Chelsea	BS
Brent	QK	Kingston upon Thames	VK
Bromley	PY	Lambeth	LX
Camden	EK	Lewisham	PL
City Of London	CI	Merton	VW
Croydon	ZD	Newham	KF
Ealing	XB	Redbridge	JI
Enfield	YE	Richmond upon Thames	TW
Greenwich	RG	Southwark	MD
Hackney	GD	Sutton	ZT
Hammersmith & Fulham	FH	Tower Hamlets	HT
Haringey	YR	Waltham Forest	JC
Harrow	QA	Wandsworth	WW
Havering	KD	City of Westminster	CW
Hillingdon	XH		

Appendix 2: Issues for consideration in relation to the rapid response process

	The strands to consider	**Phase one: 0-5 days**	**Phase two: 5-7 days (initial pm)**	**Phase three: 8-12 weeks (final PM)**
CHILD DIES, notify LSCB of all deaths and refer to all strands	**Strand 1: Care of families**	Supporting families	Supporting families	Supporting Families
		Care and protection of siblings	Care and protection of siblings	Care and protection of siblings
		Care of parents	Informing parents, with reference to coronial and criminal issues	Informing parents, subject to outcome of coronial and police enquiries
	Strand 2: Deciding on response	Expected and explained deaths, follow normal protocols	Follow normal protocols	Follow normal protocols
	Strand 3 (a): Rapid response	**Unexpected deaths: proceed to Rapid Response procedures: notify agencies, discuss and agree immediate actions**	**Multi-agency case discussion/meeting**	**Multi-agency case meeting**
			Consider and agree on need for home visit	**Refer to home visit record**
			Consider initial PM results	**Consider Final PM results**
		Notify coroner	**Keep Coroner informed**	**Report to coroner**
		Notify the police	**Ensure planning consistent with police enquiries**	**Establish if any further police concerns**
		Notify health professionals	**Establish any clinical issues**	**Establish cause of death**
		Notify social care	**Agree on care/protection of siblings**	**Agree on care issues**
		Notify CDOP	**Inform CDOP on outcome of case discussion and/or meeting**	**Report to CDOP**
	Strand 3 (b): Notifications	**Child death information gathering and evaluation booklet**	**Child death information gathering and evaluation booklet**	**Child death information gathering and evaluation booklet**
	Strand 4: Child protection	If children in need of protection, refer to Ch 6. London Procedures.		Agree on care/protection of siblings
	Strand 5: Serious case review	Ask: does this require a serious case review? Refer to LSCB to consider.		Ask; Does this require a serious case review? Refer to LSCB to consider.

	Strand 6: Media issues	Inform LSCB about any media enquiries; LSCB will work with police to manage		Ensure all involved aware of media management strategy
	Strand 7: Support to staff	De-briefing		Engagement in process

Appendix 3: Rapid Response Flowchart



Appendix 4: *Child death information gathering and evaluation* booklet

[Awaiting publication by DCSF]

Appendix 5: Services available from Cruse Bereavement Care

- On-line access to information at www.cruse.org.uk
- Confidential Day-by-Day Helpline 0844 477 9400 and email helpline: helpline@cruse.org.uk
- Free leaflets available though the helpline, the website, and from local branches or from Cruse central office
- Individual face-to-face bereavement support from a Bereavement Volunteer
- For young people, on-line access to information, forums and support at www.rd4u.org.uk
- For young people, a freephone helpline 0808 808 1677 and private email service through www.rd4u.org.uk
- Support in a bereavement group.