Government legislation now requires every local Children’s Service Authority to review the circumstances of all child deaths up to age 18, except stillbirths. The view is, by gaining a greater understanding of all child deaths, the overall number can be reduced.

For any child that dies, the Initial Notification of the Death of a Child Form must be completed. This is then forwarded onto the relevant Single Point of Contact (SPOC) for that child’s Local Safeguarding Children Board. This should be completed by hospital medical staff or GP in some cases where palliative care has been provided in the community (See www.londonscb.gov.uk list of contact details for all London SPOC)

The Child Death Overview Panel (CDOP) is made up of professionals from Health, Children Services, Police and other Safeguarding members. These members have the responsibility of evaluating the reports and information provided regarding local child deaths. They may provide recommendations regarding issues such as public health, practice or inter agency working (See London Child Death Panel Procedures www.londonscb.gov.uk)

The Rapid Response Process starts at the point of death (See London Rapid Response Procedure www.londonscb.gov.uk) considering support for the family, any safeguarding issues and ensuring SPOC has been notified. The Rapid Response Meeting (RRM) is a significant part of this process where all unexplained / unexpected child deaths in both the hospital and community will be reviewed. Prior to the initial RRM the appropriate professionals should start the process of completing Form B (National Templates for Collecting Information about Child Deaths, including Form B2 – B10 where necessary, (www.everychildmatters.gov.uk))

**Phase One.** Focus on support for the family, care and protection of other children, information sharing and notifying agencies

**Phase two** (Initial RRM) is around the 5-7 working days after the death. It is at this stage, professionals involved in the child’s care prior to death are likely to be invited to attend. This meeting will consider support for the family, any safeguarding issues regarding other children, if the case should be forwarded onto the LSCB for consideration under the Serious Case Review procedures, any clinical issues and the completion of Form B

**Phase Three** (Second RRM) will be around 8 – 12 weeks (once the final post mortem is available, if applicable). Similar to the Initial RRM support for the family and clinical issues will be considered including the final post mortem or coroners report. At this stage it should also be possible to complete the Form B to establish the cause of death and to make any pertinent recommendations. This could include a Serious Case Review or Management Case Review.

A Form C will be completed and passed onto the CDOP for their considerations and to make any necessary recommendations. As part of this, the CDOP is required to maintain a database of child deaths and to report back to the relevant LSCB at the end of the year. This data will also be used to assess statistical trends that might inform better service provision, the targeting of services or providing public information.

It should be noted that the information provided in this leaflet is a brief overview and anyone who is or likely to be involved in either the CDOP or RRM should read the London Child Death Overview Panel Procedure and or London Rapid Response Procedure

All the information discussed in this leaflet including forms, procedures, flow charts and similar is available on www.londonscb.gov.uk