Berkshire Protocol, Health Led Rapid Response for Unexpected Child Death

January 2016

Author:
Patricia Pease, Designated Professional, Child Death Berkshire West

Consultation:
Louise Watson, Designated Doctor for Child Protection, Berkshire
John Connell, Designated Doctor Child Death, Berkshire East
Rod Howell, Detective Inspector, CAIU, Berkshire West
Andrew Howard, Detective Inspector, CAIU, Berkshire East
Erica Hyatt, Manager, Berkshire Rapid Response Home Visit Service
Peter J Bedford, HM Coroner Berkshire, through the Coroner’s Officers

The Unitary Authorities of Berkshire through their HOCS and CDOP representatives - Bracknell, Reading, Slough, West Berkshire, Windsor and Maidenhead, Wokingham

Acknowledgement
Milton Keynes, Rapid Response Team Protocol and the London Safeguarding Children Board Rapid Response Protocol for providing the basis for this protocol

Ver 2 for review January 2018 or as needed due to change in professional contact details, local practice or national guidance.

Contents

1
1. Introduction

2. Definitions

3. Agency Roles and Responsibilities

4. Initial Multiagency Discussion/Meetings

5. Further multiagency discussion and information sharing

6. Inquest

7. After the Inquest

8. Abbreviations and Acronyms

9. Useful contacts
1. Introduction

1.1 This protocol is based on ‘Working Together to Safeguard Children, 2015 and forms the basis of the inter-agency response to an unexpected death of a child in Berkshire.

1.2 If there are concerns about abuse or neglect when a child has presented in a critical condition or contributing to the cause of death, leading to safeguarding concerns for surviving siblings, the child protection process Sec 47 strategy meeting and any criminal investigation will naturally take precedence over the Health led Rapid Response processes.

1.3 If you are satisfied that there no such concerns then please follow the protocol

1.4 A flow chart algorithm to summarise the actions described in this protocol is available, Appendix 1.

2. Definitions

2.1 "Childhood" is defined as the time from live birth (irrespective of gestation) until the attainment of the age of 18 years. By far the largest group of child deaths occurs in the perinatal period (0 - 7 days). For "rapid response" procedures these infants will not be routinely included unless involved professionals express concerns about the circumstances of the pregnancy or the death.

In the case of a newborn baby who dies in hospital within 24 hours of birth or shortly thereafter due to an event related to the birth whilst under medical supervision, and where there is a medical explanation for the death this should not be treated as an unexpected death.

If a baby dies in the same circumstances (i.e. whilst under medical supervision), with no immediate medical explanation apparent, and where a there is an indication or suspicion of risk factors DA/substance abuse/concealed pregnancy the situation should be discussed with the Designated Doctor/Professional for Child Death to make a decision (informed by the circumstances surrounding the death and information available to them within Health) as to whether the case should be regarded as an unexpected death and so trigger a Rapid Response process.

If a baby dies in the same circumstances (i.e. whilst under medical supervision), with no immediate medical explanation apparent, and where a there is an indication or suspicion of physical cause e.g. smothering/forced feeding a Rapid Response process should be triggered.
If a dead baby is brought into hospital having been born without medical assistance (regardless of gestation) a rapid response process should be triggered. The maternity co-ordinator must be informed to help co-ordinate care for Mother and so that maternity staff are aware that the rapid response process is underway. This process can be halted if following examinations it is found that baby was either stillborn or gestational age is below viability.

In the case of a concealed pregnancy please refer to the ‘Berkshire Multiagency Guidance on the Management of Concealed Pregnancy’ found on the Berkshire LSCB Child Protection procedures website.

2.2 "Responsible consultant" has been used to identify the senior involved clinician, this is most likely to be a paediatrician but when the death is that of a young person of over 16 years the clinician will be an adult specialist and some interpretation of the protocol depending on age and mode of death may be required with the support of the paediatrician on call if necessary.

2.3 "Unexpected death" is defined in Working Together to Safeguard Children 2015 (paragraph 7.21) as the death of an infant or child (less than 18 years old) which:

- Was not anticipated as a significant possibility for example 24 hours before the death; or

- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

2.4 "Death" means the time that death is formally certified. It is usually not appropriate to instigate this process whilst the child is alive and receiving medical care.

2.5 In cases where the medical team have any concerns that there are issues of abuse or neglect when a child has presented in a critical condition, especially where there are other children in the household, then early discussion with Police and Children's Social Care (CSC) should take place.

This will allow for scrutiny of the CSC and Police databases as a minimum precaution, further inter-agency involvement as considered necessary and for relevant enquiries to be made by Thames Valley Police and/or the child’s local authority that may trigger a criminal and/or Sec 47 enquiry.

These preliminary enquiries can be made without informing the parents if it is considered that this will add to their distress. Information sharing protocols exist between police and social services to ensure that relevant information is shared without the consent of the parents / carers if the public interest is deemed to outweigh the wishes of the parents / carers.

The Rapid Response process will be triggered for any child who is resident in Berkshire,
even if the death occurs elsewhere in the UK or overseas. In addition, the Rapid Response process will be started locally for a child who dies unexpectedly in Berkshire who is not a resident and handed over to the Rapid Response team in the child’s place of residence as soon as practicable.

3. Agency Roles and Responsibilities

3.1 Once a child has been declared dead, the Coroner has jurisdiction over the body and all that pertains to it. The police (including specific coroners officers) will often act on behalf of the coroner and will likewise have jurisdiction over the body in such circumstances as police acting on behalf of the corner.

3.2 The majority of unexpected deaths in childhood are natural tragedies, but a minority are a consequence of ignorance, neglect, abuse or homicide. The investigation should keep an appropriate balance between medical and forensic requirements and the needs of the family in coping with the tragedy. Account should be taken of possible risks to other children in the household.

3.3 Professionals should approach the investigation with an open mind and families should be treated with sensitivity, discretion and respect. Professionals must be aware that as the number of child deaths due to natural causes decreases, the proportion of such deaths which could be attributed to neglect or abuse is likely to increase.

3.4 There should be a multi-agency approach involving collaboration among: emergency department (ED) staff, ambulance staff, named and designated doctors and nurses in child protection, Coroners, coroners’ officers, general practitioners (GP’s), health visitors, midwives, paediatricians, pathologists, police, children’s social care and education.

3.5 In each agency a senior person with suitable training and experience should be identified as having responsibility for implementation of the protocol, including continuing training for all relevant staff.

3.6 The Designated Paediatrician/Professional for Child Death will take the strategic lead for rapid response within Health, but the input at senior level in individual cases will be from the consultant involved in the initial event (responsible consultant).

3.7 The Duty Detective Inspector for the Local Police area will lead for the Police on initial rapid response to Child Death. Subsequent enquiries will be led by the Local Police area Detective Inspector for the Child Abuse Investigation Unit and the Team Manager (referral and assessment) for the local authority.

3.8 Children found dead at home should usually be taken into the emergency department,
not to the mortuary, and resuscitation should be initiated unless clearly inappropriate. There are situations where it is obvious that a body is beyond resuscitation and needs either to remain at the death scene for forensic purposes or to be moved to a mortuary. This will be a decision for the police in consultation with the Coroner.

3.9 On arrival in the emergency department the parents/carers should be allocated a member of staff to care for them and should normally be given the opportunity to hold and spend time with their child at a later point while in the department. The parents/carers should also be offered mementoes e.g. a lock of hair or a photo.

3.10 As soon as possible after arrival, the child should be examined by the responsible consultant and a careful history should be taken from the parents.

3.11 A set of investigative samples should be taken. A protocol which includes a standard set of samples in the case of Sudden Unexpected Death in Infancy (SUDI) is available on the Safeguarding section of the RBFT intranet. Similarly, guidelines for medical management and post-mortem samples in the event of sudden unexpected infant/child death are available on the Wexham Park intranet.

3.12 When the child is pronounced dead, the responsible consultant should inform the parents/carers, and explain police and Coroner involvement and the need for a post-mortem examination.

3.13 If not already present in the Emergency Department the Police should be informed immediately.

3.14 2-4 hours at the latest after death has been confirmed, notification should be given to the Coroner (via the on call Coroner’s Officer) and Children’s Social Care. Out of hours this will be the Emergency Duty Team (EDT) for Berkshire.

3.15 During the 2-4 hours after death there should be consideration of the need for a home visit if the unexpected death involves an infant < one year or the child has not been brought to hospital.

If a home visit is required the Berkshire Rapid Response Service provided by BHFT must be contacted.

3.16 The primary care team and other agencies involved with the child must be informed the next working day about the death.

3.17 Further notification of the child’s death, should be made to the CDOP administrator:
For Berkshire West through the Named Nurse for Child Protection at the RBFT.
For Berkshire East through the Named Nurse for Child Protection at Wexham Park.

3.18 When a child goes directly to the mortuary the Designated Doctor/Professional for Child Death must be informed.
4. Initial Multiagency Discussions/meetings

4.1 Triggering the Rapid Response process for Unexpected Child Death

Rapid Response is an information sharing process that is triggered at the time of the child’s death.

Rapid Response is most often triggered in the Emergency Department when a child or young person dies after transfer by 999 ambulances although it must be triggered in the same way when a child or young person dies unexpectedly in any setting, including a Paediatric Ward, a Neonatal Unit, ICU or an Adult Ward.

The Rapid Response process should be triggered when a child or young person with a life limiting/chronic illness dies unexpectedly unless there is an ‘End of Life Plan’ in place.

4.2 At the time of an unexpected child death 24/7

If the child dies in hospital the Consultant Paediatrician/ED Consultant or a senior nurse or doctor on behalf of the consultant informs the following agencies about the unexpected death and shares information about the circumstances of the death, with particular reference to other children under 18 years and vulnerable adults in the household.

- Thames Valley Police (TVP)
- Children’s Social Care, Berkshire Emergency Duty Team (EDT) out of hours child’s local authority, access and assessment team 9 – 5 Mon – Fri.
- The coroner’s officer on call

Consider who is caring for other children and vulnerable adults, their welfare and safety.

The police should respond by sending the Duty DI to the hospital to be present when the Consultant Paediatrician (usually) or the ED Consultant carries out a ‘top to toe’ visual examination of the child and speaks to the family.

The police will also send a senior officer to the ‘scene’ of the incident/collapse that led to the child’s death, usually the family home but not always.

The police should check their data base and respond by sharing pertinent information.

Children’s’ Social Care should check their data base and respond by sharing information about the child/family involvement with children’s services to allow for a multiagency risk assessment and decision about urgency of need and support.

The responsible consultant, the senior investigating police officer and the duty team at Children’s Social Care should have a multiagency information sharing discussion to
determine if there is anything suspicious or if there are any child protection concerns.

This is usually done by telephone led by the responsible consultant but should be initiated by the Duty DI, TVP if the child dies out of hospital. If the child dies outside hospital and is not conveyed to hospital after death, this discussion should involve the on-call BHFT Rapid Response Professional who can provide health input to the discussion.

The decisions made and actions agreed during the initial multiagency information sharing meeting must be recorded by the responsible consultant on the ‘Unexpected Child Death Discussion Form’ and copies should be shared with TVP and CSC within 12 hours of the discussion (Appendix 2)

During this discussion consideration should be given to the need for a home visit. This should usually take place in the case of sudden unexpected death in infancy. If a home visit by a health professional is indicated, this should be undertaken, preferably within 24 hours of the death, by the BHFT rapid response professional.

Health professionals should follow the ED check list for unexpected child death, which has been designed with the police and children’s services to address the need for a proportionate response that supports multiagency procedures and the needs of the family (Appendix 3)

4.3 Decision to hold a Health led Rapid Response meeting.

A Rapid Response discussion about the circumstances between the Consultant Paediatrician/ED Consultant and Designated Doctor/Professional for Child Death should happen as early as possible the next working day.

In Berkshire West please email Patricia Pease, Designated Professional for Child Death with brief details including the child’s initials, DOB, DOD and who should be contacted and how e.g. mobile number the next working day to gain more information, including a copy of the child’s notes.

patricia.pease@royalberkshire.nhs.uk
and copy
j.higson@nhs.net
joanne.horsburgh@nhs.net
catherine.hiskett@royalberkshire.nhs.uk
carrie.wilkins@royalberkshire.nhs.uk

Patricia Pease has a secure landline messaging facility, 0118 322 Ext 8253 to support communication 24/7.

During working hours Monday – Friday there is a single point of contact mobile number 07795120628 for unexpected child deaths in Berkshire West.

In Berkshire East please contact Dr John Connell Designated Doctor for Unexpected Child Death on 01753 635530.
Please email brief details including the child’s initials, DOB, DOD and who should be contacted and how e.g. mobile number the next working day to gain more information, including a copy of the child’s notes to:

john.connell@berkshire.nhs.uk
and copy
elaine.welch1@nhs.net
sheila.eames@nhs.net

The Designated Doctor/Professional for Child Death continues the Rapid Response discussion with CAIU and the child’s Children’s Social Care services to determine the most appropriate date/time for an initial case discussion Rapid Response meeting.

If it is necessary to convene a face to face meeting this will usually be within 1-5 days of the death depending on the circumstances of the death and the availability of relevant professionals.

In some cases where the cause of death is fully explained and no concerns have been identified through multi-agency discussion (for example after a road traffic accident), a face to face meeting may not be necessary.

It is the responsibility of the Designated Doctor/Professional for Child Death to liaise with other lead agencies to make a joint decision whether or not to hold a meeting and to agree the timing of the initial case discussion meeting.

In the case of a child who is not usually resident in Berkshire these discussions and any meeting will need to involve their home Local Authority and the relevant police force. Where the child who has died, or a child in the same household, is an open case to Children’s Social Care, the responsible Team Manager should discuss the case with their Service Manager to determine whether a Child Protection Sec 47 Strategy Meeting, chaired by the Children’s Social Care is needed. This decision will be dependant on the nature of the involvement. If there are concerns about abuse or neglect contributing to the cause of death, leading to safeguarding concerns for surviving siblings, the child protection process, section 47 strategy meeting and any criminal investigation will naturally take precedence over rapid response child death processes.

If held, the Sec 47 Strategy Meeting should take place within 24hrs of the death and the Consultant Paediatrician and/or Designated Doctor/Professional for Child Death should be invited. If the Designated Doctor/Professional for Child Death is present at the Sec 47 Strategy meeting an initial case discussion Health led Rapid Response meeting may be held consecutively.

The following professionals are always invited to and asked to provide written verbal or written reports to initial Health led Rapid Response meetings:

Responsible Paediatrician
Child Abuse Investigation Unit, Thames Valley Police
Children’s Social Care
NHS Safeguarding Team
Midwife/Health Visitor/School Nurse
South Central Ambulance Service
Public Health Consultant for locality
General Practitioner and Out of Hours GP Service if relevant
Education (Head Teacher of Child’s School or representative) if relevant
Other relevant agencies e.g. CAMHS, Probation Service, South Central Ambulance

...
Service

In Berkshire East and West:

- Draft minutes will be circulated to attendees with in 5 working days
- Subject to corrections final minutes will be circulated and sent to the attendees, Coroner’s Officer, the Designated Nurse for Child Protection and the Head of Legal Affairs at the RBFT within 10 working days.

The Police have a responsibility to investigate all unexpected deaths of children on behalf of the Coroner. The role of the Designated Professional for Child Death at this stage is to ensure all activity between agencies is carried out in a co-ordinated fashion.

Where there are immediate concerns that abuse or neglect has been a factor in the child’s death, the case will be subject of a joint investigation involving the Police and Children’s Social Care from the outset.

In these circumstances Children’s Social Care have the responsibility for co-ordinating the overall safeguarding investigation and the police have responsibility for coordinating any criminal investigation.

4.4 Decision for a home visit by a Health Professional to take place.

A Berkshire wide service to provide a home visit, for unexpected child deaths where the child does not die in a hospital setting within 24 hours is provided by BHFT.

This service is provided by a team of Health Visitors/School Nurses with specific training, supported by the Designated Doctor for Child Death for East Berkshire.

In the event of an unexpected child death where the child does not die in a hospital setting The Duty DI, the Local Police Area, TVP should contact the Berkshire Rapid Response Service.

This team also provides a home visit service for all sudden unexpected death in infants < 1 year (SUDI) within 24 hours and will discuss home visits for all children < 5 years on an individual case by case basis.

In the event of a SUDI, if the next working day is a weekday the Named Nurse for Child Protection at the Royal Berkshire and Wexham Park Hospitals will contact the Berkshire Healthcare Foundation Trust Rapid Response home visit team, to arrange for a visit to the family home, if the death occurs out of hours on Friday or Saturday the Consultant Paediatrician should contact the team to allow for a timely visit.

A record of these discussions will be made and a record and report from any home visit will be made using standardised documentation available to the rapid response professionals. A copy of this report will be sent to the Designated Doctor/Professional for Child Death for the information to be shared with the multiagency team and forwarded to the Pathologist and Coroners Officer.

Contact details: 01628 632012
5. Further Multiagency Discussion and information sharing

5.1 If the death is suspicious or significant concerns are raised at any stage about the possibility of abuse or neglect, a decision will be taken for the police to become the lead agency, and take primacy in the investigation. In this case the police must inform a Senior Investigating Officer (SIO) from Major Crime, who will take responsibility for investigating the child's death. In these circumstances consultation must take place with the police, to ensure no compromise of information to the parents/carers or those close to them, who may be responsible for or contributed to the cause of death. Otherwise Health remains the lead agency.

5.2 If it is thought at any time that the criteria for a Serious Case Review might apply, the relevant Berkshire LSCB Chair should be contacted and the Serious Case Review Procedures should be followed.

5.3 If it is thought at any time that the criteria for a mandatory single agency review of practice e.g. Serious Incident Requiring Investigation (SIRI) for health providers might apply the Designated Doctor/Professional for Child Death should contact the relevant organisation.

5.4 When a baby or older child dies unexpectedly the police are responsible for investigating the circumstances of the death, and may have to secure the death scene. There will be a visit to the scene of the death (preferably within 24 hours). This visit is by the Police initially but if there are aspects for which they require health input they will secure the scene and request assistance from the Berkshire Rapid Response Service. The Nurse on call will advise on the appropriate person to visit. When a health professional undertakes a visit they should discuss their findings with the Designated Doctor/Professional to pass on to the pathologist and should compile a written report for the case discussion. The Police are responsible for providing the Coroner with a report from the scene visit and subsequent investigation into the death.

5.5 The responsible consultant will provide a verbal summary of the events to the Coroner’s Officer for the Coroner and Pathologist. This includes circumstances of the death, relevant findings, the history obtained in hospital and a review of relevant medical records. This will include the contact details for the responsible consultant in order that either Pathologist or Coroner may seek clarification as needed and for the forwarding of the post mortem report. A copy of the child’s clinical notes will be provided to the
coroner’s officer for the Pathologist.

5.6 The coroner will order a post-mortem examination to be carried out as soon as possible, preferably within 48 hours, by the most appropriate pathologist. In most cases, this will be a paediatric pathologist, following a recommended protocol, but if significant concerns have been raised about the possibility of homicide, abuse or neglect, a Home Office approved paediatric pathologist should take the lead. If the post-mortem examination reveals no sufficient identifiable cause of death, whether or not any concerns have been raised during the post-mortem examination or previously about the possibility of abuse or neglect, the pathologist should categorise the death as "unexplained pending further investigations" and the coroner should in every case hold an inquest.

5.7 If the post mortem indicates death from abuse or neglect:

- The Police will commence a criminal investigation;
- Action will be taken to safeguard other children in the household;
- The relevant Berkshire LSCB should be notified, via LSCB Business Manager

5.8 The post mortem report will be forwarded to the responsible consultant and to the Designated Doctor/Professional for Child Death. Either (or both together) should discuss the results of the post mortem with the parents/carers at the earliest opportunity:

- If the Coroner does not want such a discussion prior to the Inquest the rider “not to be discussed” will be added to the autopsy report;
- If the Police have taken over as lead agency because of concerns over abuse or neglect then the role for and conduct of such a meeting will be discussed;
- If the post mortem findings are unclear or controversial the responsible consultant/Designated Doctor/Professional for Child Death and the Coroner/Police will discuss on a case by case basis;
- There may be further reasons not to hold a meeting, for example where the Inquest is to take place soon after the release of the post mortem report or when there are issues around litigation.

5.9 The parents/carers will receive written information advising that the child’s death will be subject to a review by the Child Death Overview Panel (CDOP) in order to learn any lessons that may help to prevent future deaths of children. The parents may ask for and have a right to receive the minutes of any Health led Rapid Response meeting (see
6. Inquest

6.1 The purpose of an Inquest is to determine

- Who has died;
- When and where the death occurred;
- How the cause of death arose.

6.2 HM Coroner in Berkshire decides if an Inquest is necessary for sudden unexpected death in childhood. It is at Inquest that the cause of death is agreed. The information shared as in the above paragraphs will contribute to this process.

7. After the Inquest

7.1 If the verdict of the inquest is that abuse and neglect caused or contributed to the death the Police and Children’s Social Care will act accordingly and the need for a Serious Case Review will be considered (if these have not previously occurred).

7.2 If the child’s family have any unanswered questions concerning the death the Designated Doctor/Professional for Child Death or the responsible consultant (or both) will meet them to answer their questions. If the family do not wish contact this may be done by letter.

7.3 The Designated Doctor/Professional for Child Death will consider whether a professionals case review meeting is required to consider the needs of other children in the family or future children and any additional learning and will convene and chair this meeting.

7.4 In the case of SUDI it should be noted that if there are subsequent pregnancies in the mother will be offered a referral to the Care of the Next Infant (CONI) programme at booking.

6.5 All information and the standard data set will be forwarded to the Child Death Overview Panel.
# 8. Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHFT</td>
<td>Berkshire Healthcare Foundation Trust</td>
</tr>
<tr>
<td>CAIU</td>
<td>Child Abuse Investigation Unit</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
</tr>
<tr>
<td>CDOP</td>
<td>Child Death Overview Panel</td>
</tr>
<tr>
<td>CONI</td>
<td>Care of Next Infant</td>
</tr>
<tr>
<td>CSC</td>
<td>Children's Social Care</td>
</tr>
<tr>
<td>DI</td>
<td>Detective Inspector</td>
</tr>
<tr>
<td>DOB</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>DOD</td>
<td>Date of Death</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department (Accident and Emergency Department A&amp;E)</td>
</tr>
<tr>
<td>EDT</td>
<td>Emergency Duty Team Berkshire wide Out of Hours Social Care Service</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HWPHFT</td>
<td>Heatherwood and Wexham Park Hospitals Foundation Trust</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>LSCB</td>
<td>Local Safeguarding Children Board</td>
</tr>
<tr>
<td>SID</td>
<td>Sudden Infant Death</td>
</tr>
<tr>
<td>SIO</td>
<td>Senior Investigating Officer (Police)</td>
</tr>
<tr>
<td>SIRI</td>
<td>Serious Incident Requiring Investigation (Health providers)</td>
</tr>
<tr>
<td>SUDI</td>
<td>Sudden Unexpected Death of an Infant</td>
</tr>
<tr>
<td>TVP</td>
<td>Thames Valley Police</td>
</tr>
</tbody>
</table>
9. Useful Contacts

**Berkshire wide:**

Social Care Emergency Duty Team out of hours team 01344 786543

Rapid Response Service BHFT 01628 632012 – in and out of hours

Berkshire Designated Doctor for Child Protection, Dr Louise Watson, Child Development Centre, Fir Tree House, Upton Hospital, Slough. 01753 635530
louise.watson@berkshire.nhs.uk

Manager for Berkshire Rapid Response Service, BHFT, Erika Hyett Tel: 01753-636752, Mob: 07736723684, erika.hyett@berkshire.nhs.uk

Named Professional for Safeguarding, BHFT, Fiona Morris Mob: 07979502929
fiona.morris5@nhs.net

Named Professional for Safeguarding , SCAS Antony Heselton, Mob: 07803760616 Secure fax: 01494 474794 SCAS email antony.heselton@scas.nhs.uk
antony.heselton@nhs.net

Child Death Overview Panel Coordinator, Lorna Tunstall, Slough Borough Council, 2nd Floor West Wing, St Martin's Place, 51 Bath Road, Slough, SL1 3UF.
Tel: 01753 875149, Mob: 07850 209095 Fax: 01753 478653.
Email: lorna.tunstall@slough.gov.uk Email:berkscdop.admin@slough.gcsx.gov.uk

**Berkshire East:**

Berkshire East Designated Doctor for Child Death, Dr John Connell, Child Development Centre, Fir Tree House, Upton Hospital, Slough. 01753 635530.
john.connell@berkshire.nhs.uk

Wexham Park and Heatherwood Hospitals, FHFT Named Nurse for Child Protection, Elaine Welch 01753 634609 elaine.welch1@nhs.net

Wexham Park and Heatherwood Hospitals, FHFT Named Doctor for Child Protection, Dr Fiona Regan 01753 633810 fiona.regan@fhft.nhs.uk

Berkshire East CAIU DI, Andy Howard, Tel: 01753 835483 Mob: 07974 974085 andy.howard@thamesvalley.pnn.police.uk

Bracknell Referral and Assessment Tel: 01344351582 Fax: 01344351521

Slough Referral and Assessment 01753 690 814
Windsor & Maidenhead Referral and Assessment 01628 683150 rat@rbwm.gcsx.gov.uk

Berkshire West:

Berkshire West Designated Professional for Child Death, Patricia Pease UCG Director of Nursing, Level 3, Main Entrance, Craven Road, Royal Berkshire Hospital, Reading.  
Tel: 0118 322 8253 patricia.pease@royalberkshire.nhs.uk

During working hours Monday – Friday there is a Rapid Response single point of contact mobile number 07795120628 for unexpected child deaths in Berkshire West.

Berkshire West Designated Nurse Safeguarding, Berkshire West Clinical Commissioning Groups 57- 59 Bath Road, Reading, RG30 2BA. Tel: 0118 952 5435; Fax 0118 982 2914 j.selim@nhs.net

RBFT Named Nurse for Child Protection, Jo Horsburgh Tel: 0118 3228046 
Fax: 01183226889 Mob: 07795266350 joanne.horsburgh@royalberkshire.nhs.uk or joanne.horsburgh@nhs.net

RBFT Named Doctor for Child Protection, Dr Ann Gordon, Consultant Paediatrician Tel: Sec 0118 3227439 Mob: 07795043782 ann.gordon@royalberkshire.nhs.uk or ann.gordon1@nhs.net

RBFT Named Midwife for Child Protection Catherine Hiskett Tel: 07768752529 catherine.hiskett@royalberkshire.nhs.uk

RBFT Senior Nurse for Children and Safeguarding, Jessica Higson, Tel: 0118 322 6998, Mob: 07776 457988 Jessica.higson@royalberkshire.nhs.uk or j.higson@nhs.net

Berkshire West CAIU DI Rod Howell, Tel: 0118 9536311 Mob: 07973 418761 rod.howell@thamesvalley.pnn.police.uk

Reading Referral and Assessment Tel: 0118 9373641 Fax: 0118 937 3741

West Berkshire (Newbury) Referral and Assessment Tel: 01635 503090 Fax: 01635 519 740

Wokingham Referral and Assessment Tel: 0118 908 8002 Fax: 0118 908 8246

Neighbouring counties:

Oxfordshire Referral and Assessment Abingdon (for Henley area): 01865 897983 Oxford city: 01865 323048 Out of hours: 0800 833 408

Basingstoke Referral and Assessment 0845 603 5620 Out of hours: 0845 600 4555