



How we review when a child dies unexpectedly

Information for Parents, Families and Carers



www.surreyscb.org.uk

The death of a child is always tragic. You will have many concerns and questions about why your child has died so suddenly and unexpectedly. Talking and thinking about a child's death is a sensitive and painful subject which is particularly upsetting for parents, families and carers.

What is a Review and why is it needed?

Since April 2008 local children safeguarding boards (LSCB's) are required by the government to review the death of a child up to the age of 18 years in order to support families and also to see if there is anything we or anyone else can do to improve services offered for children and their families in the future. It is vital that all child deaths are carefully reviewed so that we may learn as much as possible, to try to prevent future deaths and to support families.

All the information gathered for a review will be treated with the deepest respect and in strictest confidence. We promise that none of our findings, recommendations or reports will name your child or family.

Immediate response to a child's death

Apart from contact with the Hospital, Police and the Coroner's office, you will also be contacted by the Specialist Nurse with experience in reviewing child deaths who may visit where your child died and review alongside the police, the circumstances of your child's death. She will contact you soon after your child's death and will offer to visit you at home.

How does a Review happen?

Information about each child and the circumstances of their death is collected and summarised into a short report from records held by hospitals, local health services, schools, police, children's services or other agencies who knew the child.

A small group of health and child care professionals (Child Death Overview Panel) will consider the reports and review alongside the coroner what caused your child's death and what support and treatment was offered to your child and your family up to the death; and also what support was offered to your family after that time.

The group will consider whether they can make any recommendations to improve the services offered for children and their families in the future. These recommendations will be shared with the local Health Trusts, Children's Services, Police, specialist agencies such as the Fire Service or Traffic Authorities, as appropriate and the Surrey Safeguarding Children Board. www.surreyscb.org.uk

It is not possible for parents or family representatives to attend the Panel meetings. The process may take several months as we have to wait until all other enquiries are completed, such as the work of the Pathologist and Coroner, or any legal processes.

Parents are invited to contact the **Specialist Nurse for Child Death Reviews** if they wish, for advice and support and to contribute towards the review of their child's death. Contact details as follows:

Email at cdop@surreycc.gov.uk or Telephone on **07824-350491**

For further information, please visit the Surrey Safeguarding Children Board website: www.surreyscb.org.uk/parents-carers/child-deaths-bereavement-support

You might find the following contact details helpful:

Cruse Bereavement Care:

Epsom, Ewell and Mole Valley Branch: 020 8393 7238
South East Surrey Branch: 01737 772834
Guildford, Surrey Heath & Waverley Branch: 01483 565660
North Surrey Branch: 01932 571177
Website: www.cruse.org.uk

The Compassionate Friends:

Helpline - 0345 123 2304
Email - helpline@tcf.org.uk
Website: www.tcf.org.uk

Child Death Helpline:

Freephone Landline - 0800 282 986
Freephone from Mobile - 0808 800 6019
Email contact@childdeathhelpline.org
Website: www.childdeathhelpline.org.uk

Sands -Still birth and Neonatal Death Charity:

Helpline: 0808 164 3332
Email: helpline@uk-sands.org
Website: www.uk-sands.org