How we review when a child dies

Information for Parents, Families and Carers

www.surreyscb.org.uk
There are no words to describe how difficult the death of a child is for any family. This leaflet explains what happens in the child death review process. Talking and thinking about a child’s death is a sensitive and painful subject which is particularly upsetting for parents, families and carers. This leaflet also provides a list of organisations that you may find useful.

**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 the strictest confidence. We promise that none of our findings, recommendations or reports will name your child.

**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 them.

A small group of health and child care professionals (Child Death Overview Panel) will consider the reports and review 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. In certain, limited circumstances the Coroner will conduct his own independent investigation into a child’s death, known as an Inquest.

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.surreyঃscb.org.uk

Unfortunately it is not possible for parents or family representatives to attend the Panel meetings but we invite you to share any issues surrounding your child’s death which you feel would be beneficial to the panel’s discussion.

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. The Specialist Nurse will inform you of any major recommendations made as a result of the discussions.

**Contact details as follows:**

Email at cdop@surreyঃcc.gov.uk or Telephone number 07824-350491

For further information, please visit the Surrey Safeguarding Children Board website: www.surreyঃscb.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 Bereavement UK:**
Telephone: 0800-0288840
Email: support@childbereavementuk.org
Website: childbereavementuk.org

__________

**Sands - Still birth and Neonatal Death Charity:**
Helpline: 0808 164 3332
Email: helpline@uk-sands.org
Website: www.uk-sands.org

__________

**HM Coroners Court:**
Address: Station Approach, Woking GU22 7AP
Telephone: 01483 776138