Bereavement Counselling

Working within the team at Wandsworth, Patricia McGurk is a Bereavement Counsellor, specialising in working with parents who have experienced the death of a child.

You can arrange to meet Patricia, to discuss how she may be able to help co-ordinate your bereavement support, by contacting her on: 020 8725 3711 (direct line) or email: patricia.mcgurk@nhs.net

The Coroner

In certain circumstances, deaths must be reported to the Coroner. This will have been explained to you by the doctors following your child’s death, if it is required. Whilst the Coroner is totally independent of the process, he/ she will be asked to share any relevant information concerning the death of your child with the Panel. We will also share our information with him/ her.

Contacts and Website

The Wandsworth Child Death Overview Panel can be contacted via 020 8725 3756 or email: wandsworth.cdop@nhs.net. Please ask for the Child Death Overview Panel Manager, Kelly Slade, or the Chair of the Child Death Overview Panel, Dr Peter Green.

Further information about the Child Death Overview Panel can be found on the Wandsworth Safeguarding Children Board website: www.wscb.org.uk or from the Government Guidance Working Together to Safeguard Children 2015.

Other Useful Contacts

Child Bereavement UK
Helpline: 01494 568900
www.childbereavementuk.org

The Compassionate Friends
Helpline: 0345 123 2304
www.tcf.org.uk

CRUSE Bereavement Care
Helpline: 0808 808 1677
www.cruse.org.uk

The Lullaby Trust (Formerly FSID)
Helpline: 0808 802 6868
www.lullabytrust.org.uk

SANDS (Stillbirth and Neonatal Death Society)
Helpline: 020 7436 7940
www.sands.org.uk

Child Death Helpline
Helpline: 0800 282986 / 0808 8006019
www.childdeathhelpline.org.uk

MAY 2018
**Introduction**

This leaflet is for parents and carers of a child under the age of 18 who has died. It tells you what happens in the child death review process.

The death of any child is a tragedy. It is therefore very important that all such child deaths are carefully reviewed so that we may learn as much as possible from them with a view to preventing future deaths and to support families effectively.

These reviews have been a legal requirement since April 2008.

Talking and thinking about a child’s death is a sensitive, very difficult and painful subject. We understand that this can be particularly upsetting for parents, families and carers. This leaflet also provides a list of organisations that you may find useful.

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**Child Death Review Process**

**Expected Deaths**

If your child had a long term illness or life limiting condition, and death was anticipated or inevitable, it is likely that your family and the team supporting you will have made an appropriate ‘care pathway’ together. This might include an end of life care plan for your child. Local health care staff or others such as hospice or hospital staff should work with you and your family to provide support.

**Unexpected Deaths**

An unexpected death is often sudden. Unexpected means not expected in the 24 hours before the death or before the event that led to the death. The death may have no obvious cause, such as ‘cot death’, or the cause might be clear, such as an accident.

The law requires all sudden and unexpected deaths to be reported to the coroner and the police if the cause is unknown or not attributable to a natural cause.

In the event of an unexpected death a Multi-Agency Rapid Response will begin.

**Multi-Agency Response following an “unexpected death”**

This “response” is conducted by a group of key professionals who come together to enquire into a sudden and unexpected death of a child.

This may mean a visit (but not always) to where your child died by a police officer, health professional and/ or social worker. This would take place within the first few days following your child’s death.

This response is led and coordinated by a children’s doctor called a Designated Pediatrician.

**What is the purpose of the Multi-Agency Rapid Response?**

The purpose of the Multi-Agency Rapid Response is to gather background information from other professionals/ services such as school health, education and maternity services.

It is also to ensure that the support offered to you and your family is coordinated.

**The Child Death Overview Panel (CDOP)**

The death of all children under the age of 18 must be reviewed by a CDOP on behalf of Wandsworth Safeguarding Children Board. The CDOP meets several times a year to review all child deaths in their area.

The CDOP has representatives from Public Health, local Child Health Service, Children’s Social Care Services and Police. Other professionals may be invited to give specialist advice when needed.

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**CDOP Review**

The CDOP reviews all the information about each child’s death and then considers whether they can make any recommendations to improve services for children and their families.

These recommendations will be shared with:
- The local Health Trusts
- Children’s Social Care Services
- The Police
- Specialist agencies, if appropriate, such as the Fire Service or Traffic Authorities.

These recommendations may assist in the planning of services for children and families in the future. A report with any recommendations is prepared for the Wandsworth Safeguarding Children Board. The panel is also there to ensure your family gets the right support following your child’s death. You may, if you wish, write to the Chair of the Panel at any time.

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**Parents/ Carers may feel able to contribute**

Parents are invited to share information about their child that they feel may help the process. It is not possible for parents or family representatives to attend the Panel meetings. However, we would be happy to let you know our findings if you would find this helpful.

All information we gather is treated with the deepest respect and in strictest confidence. None of our findings, recommendations or reports will name your child or family, other than those which may go to your GP.