The panel will consider:

- Any illness your child had
- The medical care and treatment that your child received
- Whether there have been any previous child deaths in the family
- Any issues in the family which may have had an impact on your child's life or death
- What services your child and family received and whether these could have been improved
- How your child's death compares to others and any similar factors or risk involved
- Current knowledge or research, relating to your child's death

Personal details of your child and family are kept anonymous and confidential. The names of your child and other family members will not be known by the panel. All information is treated with the sensitivity and respect.

As it takes some time to gather all the information the review may take place several months after your child's death.

Notes are taken at the meeting so that a record is made about what was discussed and any decisions that were made. These Minutes will only be shared with the professionals who attended the meeting and the Safeguarding Children Board.

Any recommendations to improve services will be sent to the organisation involved.

Useful contacts

- Child Death helpline
  www.childdeathhelpline.org.uk
  Freephone: 0800 282 986 / 0808 800 6019
- Child Bereavement Trust
  www.childbereavement.org.uk
  Freephone: 0800 028 8840
- Lullaby Trust
  http://www.lullabytrust.org.uk/
  Bereavement Support Freephone Helpline: 0808 802 6868
- SANDS (Stillbirth & Neonatal Death Society)
  www.uk-sands.org
  Helpline: 020 7436 5881
- The Compassionate Friends
  www.tcf.org.uk
  Helpline: 0345 123 2304

The Barnsley Child Death Overview Process

Information for parents and carers

BARNSLEY
Metropolitan Borough Council

Please accept our sincere condolences for the death of your child.

This leaflet is to explain how the death of your child will be reviewed by the Barnsley Child Death Overview Panel. The purpose is to learn any lessons that may help to prevent a future death and identify any improvements that can be made to services for other children and families.

The Child Death Overview Panel

The law requires local councils to have a local Safeguarding Children Board with a membership that represents all of the organisations that provide services for children. Since April 2008 Safeguarding Children Boards have been required to establish a child death overview panel to review the deaths of all children from the local area.

The panel reviews information about each child's death to decide whether anything could be learned that may improve the services provided to children by the organisations represented on the Barnsley Safeguarding Children Board.

Sadly many child deaths are not modifiable or preventable, but the panel needs to consider all deaths to get an overall understanding.

If your child died unexpectedly

We will be asking you questions to find out as much as possible about your child's health and the circumstances that led to their unexpected death.

The first part of the investigation will involve a specialist children's doctor called a consultant paediatrician, the police, the coroner's officers and another children's doctor who carries out the post mortem examination (the pathologist) acting on the coroner's instructions. Depending on the circumstances of your child's death, other expert help or advice may be sought.

The consultant paediatrician may visit you as soon as possible together with a police representative. They will collect as much information as they can about the circumstances leading to your child's death. This information is shared with the coroner and pathologist to help with the post mortem examination and investigations.

The initial post mortem examination findings will usually be available after a few days. The coroner's officer or consultant paediatrician will usually keep you informed if there are any significant findings. However, it may not be possible at this early stage to be able to provide a complete picture of why your child died. Further detailed tests may have to be arranged and the results can take up to 12 weeks or more. This might seem a long time to wait, but it is important that the investigation is thorough.

The consultant paediatrician will meet with selected professionals who were involved in your child's life and death, to examine all the information that has been collected so far. This meeting will usually involve the pathologist, your child's GP, the health visitor or other health professionals and representatives from the police, social care and sometimes other children's services.

After this meeting, minutes (a written record of what was discussed) are shared with the coroner to inform the inquest. The consultant paediatrician will offer to meet with you again to share the information from the meeting and results of the post mortem and try to answer your questions. This can be done at your home or elsewhere if you prefer.

The Child Death Overview Panel meeting

Panel membership includes representatives from all the organisations that may have contact with children, such as doctors, other health specialists, police and social care services.

The panel will receive information from all organisations involved with your child to help build a picture of your child's health and the circumstances that led up to your child's death.