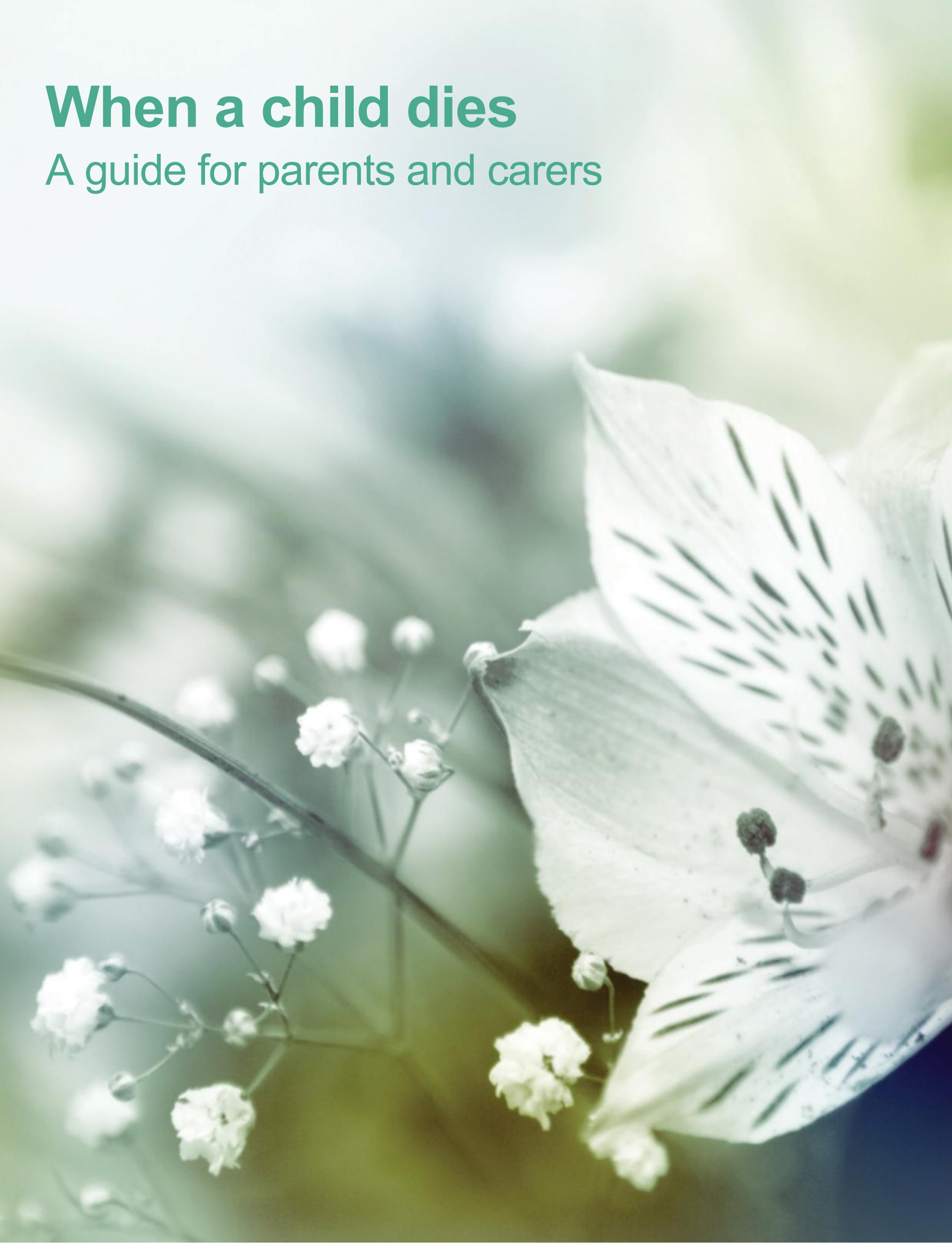
When a child dies

A guide for parents and carers



The National Child Mortality Database (NCMD) **is an NHS England funded program**

NCMD
National Child Mortality Database

Contents

Introduction 3

Part 1

A summary of what happens when a child dies 4

Keeping you informed 5

- The role of your key worker 5
- Other professionals 5

Soon after your child dies 6

- Medical Certificate of Cause of Death 6
- Children with a long-term or life-limiting condition 6

Potential further investigations 7

- How long will investigations take 7
- What the coroner does 7
- Post-mortem examination and the role of the pathologist 8
- A post-mortem examination may help to understand why your child died 8
- The coroner's inquest 9
- When joint agencies are involved 10
- An NHS Patient Safety Incident Investigation 11

The conclusion of the Child Death Review 12

- Local discussions about your child's death 12
- Regional discussions about child deaths – the Child Death Overview Panel 13
- National Child Mortality Database (NCMD) 14

If the Child Death Review process has not been followed 14

Part 2

Things for you to do 15

- Support 15
- Registering your child's death 15
- Planning your child's funeral 15
- Child benefit and other payments 16
- Other things to consider 17

Where to go for more information 17

Sources of bereavement support 18

This guide has been put together by a group of bereaved parents, support organisations and professionals; it is for parents and carers of a child under 18 to help you understand some of the things that will now happen and the support that is available.

This guide should be given to you in the early days after your child has died which we know can be a difficult time. Not all the information will be relevant for you. You might want to keep this guide and read it again later.

> We had no idea what to expect when we lost our child, what would happen and who would be involved. This leaflet will provide an important insight into what might happen next, who you can expect to hear from and who you can talk to for help. We hope this leaflet will answer some of the questions you have and some you may not have thought of and should act as a useful resource to refer to later on." **Bereaved Parent**

It is important that there is a review of every child's death to learn as much as possible.

This review is designed to support you and other members of your family in understanding why your child died. It will also try to prevent other children dying from the same cause.

This guide is for parents whose child has died in England.

Part 1 of this guide covers the different aspects of the Child Death Review.

Part 2 looks at some of the things you will need to do and where to get more information and support for this.

This guide includes information about a key worker who can be your point of contact and who can signpost you to sources of support.

Your key worker is:

If you have been given this guide without a name in the box above, contact one of the professionals you have already had contact with to discuss who this person should be.

Where 'parents and carers' are mentioned, this includes the main carers for the child who may not be biological parents, such as carers, same sex partners and any other guardians.

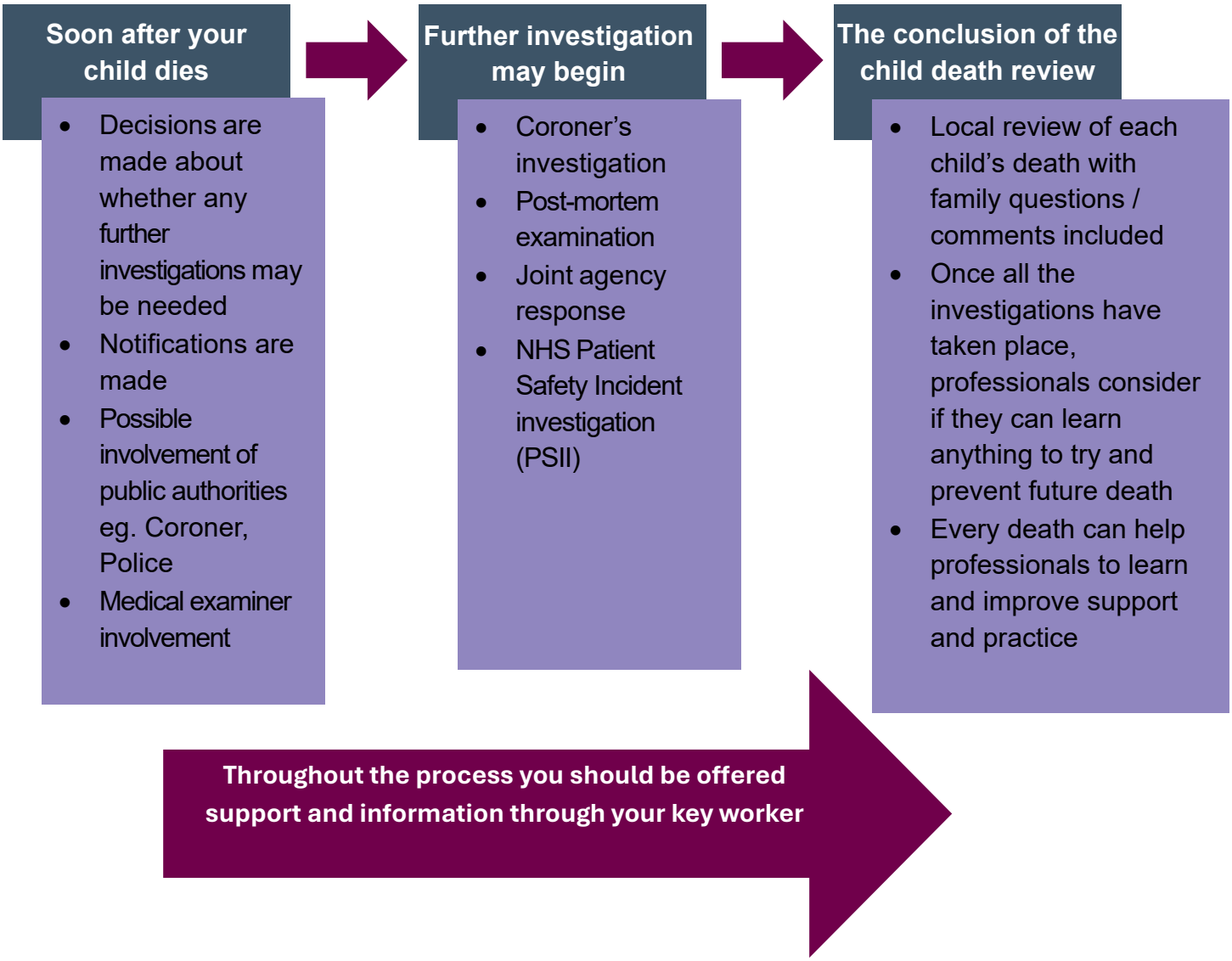
Part 1

A summary of what happens when a child dies

The death of a child is the most difficult thing any family can go through. 'Child death review' is a term used to describe the formal processes that happen after a child dies. There are some elements that take place for every child death, and some that may not be needed depending on the circumstances. Your key worker will be able to tell you about what is happening in relation to your child.

The diagram below sets out the three stages of the overall process and the different parts that may take place. Throughout this guide we refer to the 'review process' to describe this.

There is more information in this guide about each of the sections listed below.



Keeping you informed

The role of your key worker

You should be given a single, named point of contact to act as your key worker throughout any review or investigations of your child's death. This is a person who you can ask for information on the child death review process and who can signpost you to sources of support.

Your key worker will usually be a professional from the NHS or a hospice. It might be a nurse, midwife or a member of a bereavement support team. If your child had a long-term condition your family may already have an appointed professional, such as a liaison nurse, whom you know and could act as your key worker. Their role is to:

- be a reliable and readily accessible point of contact for you
- help co-ordinate meetings between you and other professionals
- clearly communicate information about the child death review process and any investigations that may be necessary
- be your voice at meetings between professionals
- ensure any questions you have are answered and fed back to you afterwards
- signpost you to appropriate bereavement support.

Your key worker should be your main contact throughout the review process

Other professionals

There are other professionals who may also have ongoing contact with you.

Coroner - If your child's death has been referred to the coroner, the coroner's officer will take responsibility for the case.

Medical Examiner –All child deaths that are not investigated by a coroner are reviewed by **NHS medical examiners.** Medical examiners are senior medical doctors, who are trained in the legal and clinical elements of death certification processes. The medical examiner will offer you the chance to have a discussion with someone not involved in providing care for your child, the medical examiner or medical examiner officer. They provide independent scrutiny of any death where the coroner is not involved.

Police - If there is a police investigation, a family liaison officer may be appointed to support you and provide a point of contact.

Other professionals can also provide support and information. They might include:

- your GP,
- social worker,
- family support worker,
- midwife,
- health visitor,
- palliative care team,
- chaplaincy or pastoral support team.

Soon after your child dies

A number of decisions will be made by professionals, including whether a medical certificate stating a cause of death can be issued and if more investigations are needed. In some circumstances, the police will be involved as standard procedure, but this does not mean that you are under suspicion.

In most circumstances you should be given time with your child

A health care professional will notify a few people about your child's death, such as your GP, and the coroner if your child died suddenly and unexpectedly.

You should be offered the opportunity to have mementoes, such as photos, a lock of hair, or hand and footprints from your child. It is fine to ask if these are not offered to you. You should also be able to spend some time with your child, but there are some situations where this cannot happen or when someone else is required to be present as well.

Organ and tissue donation may be a possibility, and the doctors should have discussed this with you. If this is something you would consider, but it hasn't been raised, speak to your key worker.

Your input to the review of your child's death is vital and professionals are expected to discuss this with you.

Medical Certificate of Cause of Death

A medical certificate of cause of death can be given by a doctor soon after your child dies, if:

- the cause of death is understood
- the death is from natural causes
- a medical practitioner has been involved in the care of the child, and
- there are no major concerns about the care provided to the child who has died.

Children with a long-term or life-limiting condition

If your child had a long-term illness or life-limiting condition, and their death was anticipated, it is likely that your family and the team supporting you will have made an appropriate 'care plan' together.

It may still be necessary for the coroner to order a post-mortem examination. Otherwise, you should be able to register your child's death quickly and proceed with your family's planned funeral and memorial arrangements.

Information on registering your child's death and planning a funeral can be found in part 2 of this guide.

Potential further investigations

In many deaths, after the immediate decisions and notifications have been made, no further investigations are required.

However, for some deaths, a number of investigations may be needed which we discuss here. They include:

- the coroner's investigation (see page 7)
- a post-mortem examination (see page 8)
- a Joint Agency Response (see page 10)
- the NHS Patient Safety Incident investigation (see page 11).
- Maternity and Newborn Safety Investigation (see page 11)

Which investigations are necessary will vary depending on the individual circumstances of your child's death. Sometimes more than one investigation may take place at the same time.

How long will investigations take?

There are recommended timeframes for investigations, but they can become delayed for various reasons. A post-mortem examination report should be issued within six to twelve months but may take longer; and a coroner's inquest should be completed within six months. Unfortunately, it may take longer in some circumstances. Your key worker or coroner's officer should know more about the expected timescale. During this time, you may wish to get support from one of the organisations listed at the end of this guide.

Accessing your child's records

To understand as much as possible about the circumstance of your child's death, different types of records from health and social care professionals may be accessed. In some circumstances your written consent might be needed, and in other situations there are legal duties to share information. Speak to your key worker if you need more information about data sharing and access to records.

What the coroner does

A coroner is someone who looks into certain types of death. Whether a coroner is involved depends on whether the death is seen as being 'natural' or not. This is a term used by coroners. A 'natural' death might be due to include extreme prematurity (when a baby is born very early in pregnancy) or an infection. Deaths from causes such as vehicle collisions and suicide would not be seen as 'natural' from a coronial perspective. If the cause of your child's death is not considered 'natural', or is unknown, or if your child died while they were under state detention (for example under a mental health section), then the law requires that the death is reported to the coroner and the police.

The coroner usually arranges for a post-mortem examination to take place for unexpected deaths, which will be carried out by a specialist doctor called a pathologist or a perinatal pathologist for babies. An inquest is held after the post-mortem examination if the cause of death remains uncertain, or if the cause of death is not thought to be 'natural'.

The coroner can open an inquest at the start of the process, or can decide to hold an investigation, which means a formal inquest hearing may not need to be held. It can be several months before the inquest or investigation is closed. Further information about inquests is given on pages 9 and 10 of this guide. You may want to ask your coroner's office for the leaflet **A Guide to Coroner Services for Bereaved People** which describes in more detail what coroners and their officers do, and what happens at inquests, if one is to be held. It is also available for download from the **Ministry of Justice Website.**

Post-mortem examination and the role of the pathologist

What is a post-mortem examination?

A post-mortem examination, also known as an autopsy, is an examination of a person after death. Post-mortem examinations for children should be carried out by a pathologist who specializes in illnesses and conditions that affect babies and children.

Can you decide if your child has a post-mortem examination?

If your child's death has been referred to the coroner, then you are not able to choose whether a post-mortem examination takes place or not. You can, however, make a representation about your wishes which the coroner can then consider.

If a coroner is not involved, then a post-mortem examination can only take place with your consent. You should have a discussion with healthcare staff to decide if a post-mortem is the right decision for you and your family.

Why is a post-mortem examination important?

A post mortem examination may help to understand why your child died

A post-mortem examination **may** do the following:

- find a medical explanation for your child's death
- rule out other diseases or problems you may have been worried about
- identify other conditions which may be important for your family to be aware of
- provide knowledge that might be used to help your family or other children in the future.

In some cases, a post-mortem examination may not find a cause of death.

What happens to your child during post-mortem examination?

When a post-mortem examination has been ordered or consented to, it takes place as soon as possible, usually within a few days. It may be necessary to move your child to another hospital where a specialist children's pathologist is based.

During the post-mortem examination the pathologist examines all the major organs and looks for any signs that might give clues as to the cause of death.

The examination is conducted with the same care as if your child were having an operation. This **video** is for families who need to decide about whether post-mortem examination is right for them.

During the post-mortem examination a number of small samples need to be taken for specialist testing. These may be called 'blocks and slides.' You will be asked what you would like to happen to these samples once the tests have been completed. You can ask for the samples to either be:

- returned to you (the coroner's officer will be able to discuss what you could do with the samples)
- kept by the hospital, as part of your child's medical record, or with your consent for use in research, future testing or other purposes, or
- sensitively disposed of by the hospital.

Some parents have found comfort in knowing their child's tissues might help research, or that future medical advances may give more information. The Human Tissue Authority (HTA) ensures that human tissue is used safely, ethically and with proper consent. More information on post-mortems can be found on their website. This video for families about tissue retention provides more information on your choices.

After the post-mortem examination has taken place and, where relevant, the coroner has given permission, you can see your child and decide where you would like your child to be before the funeral. This includes the possibility of some time at home or somewhere else such as a hospice. If it is important to you to have the funeral within 24 hours, everyone involved will do their best to enable this to happen, but the need for a post-mortem examination may mean this is not possible.

Post-mortem examination results

After the post-mortem examination, the pathologist will write a report on the findings. If more tests are required, then this may be an initial report. If the post-mortem examination was ordered by the hospital (rather than a coroner) then you will be contacted with an offer to talk about the results. You should be able to get a full copy of the report if you would like one. You can ask your key worker to help you get access to this report. This report is usually written in very 'medical' language, and it may be helpful for your key worker to arrange for a doctor to go through it with you.

For coroners' post-mortem examinations, the coroner will receive any initial findings. Where possible, with the coroner's approval, you can be given some information about these results. The final post-mortem examination report may take several months to be completed, depending on the number and type of tests conducted. The coroner will then decide how to pass the results to you.

The coroner's inquest

An inquest is a legal inquiry to:

- confirm who has died, when and where, and
- establish the cause of death in broad terms.

If the coroner decides to hold an inquest hearing, you will be given details of when and where it will take place. You may be called as a witness; in which case you must attend. If you are not called as a witness, you can choose whether to attend. You can ask questions at the inquest, and you may be asked questions. Other professionals may be present. An inquest is open to the public and journalists may be present. In some circumstances a jury may be involved.

If an inquest is going to take place, you may wish to find more support from the Coroners' Courts Support Service which is listed at the end of this guide.

When joint agencies are involved

What is a Joint Agency Response?

In certain circumstances, such as when the cause of death is not immediately clear, health professionals will work together with the police and other agencies to support you and try to understand how and why your child died. This is called a Joint Agency Response (sometimes referred to as a 'rapid response').

A joint agency response is when professionals from different agencies work together

When is it required?

A Joint Agency Response is required if your child's death:

- is or could be due to external causes (such as an accident)
- is sudden and there is no immediately apparent cause
- occurs in custody or where the child was detained under the Mental Health Act
- where the initial circumstances raise any suspicions that the death may not have been natural, or
- in the case where a baby is born at home where no healthcare professional was in attendance and the death was reported as a stillbirth.

The police will be involved in all Joint Agency Responses or where there are other circumstances that might need further investigation. This does not mean you are under suspicion; their role is to act on behalf of the coroner and to eliminate the possibility that anything unlawful has taken place.

There are three main stages to the Joint Agency Response:

1. Immediate response: Straight away: Your child will usually have been transferred to an accident and emergency department. Initial meetings between different professionals, such as the police and paediatrician, take place, and you will have been asked some questions about what happened.
2. Early response: Usually within the first week: All professionals involved will share information about your child. If your child died away from home, these professionals may visit the place of death. If your child died at home, particularly if your child was a baby, you will be visited at home. Usually this will be a joint visit by a health professional and a police officer. They will ask questions about what happened before and after your child died.

3. Later response: From one week onwards. This stage may extend over several months: More background information is gathered if required, for example health records, maternity and neonatal notes or other relevant information. The joint agency team will meet to review the information they have gathered. They will provide information to the coroner for their investigation, and members of the team will visit you to discuss their conclusions.

An NHS Patient Safety Incident investigation

If there is a possibility that something went wrong in the care the NHS provided to your child, or to you during pregnancy and childbirth if your baby died soon after birth, then it may be agreed that a patient safety incident investigation should be conducted so that the NHS can learn from what happened. If you believe that something went wrong with the care provided to your child (or to you during pregnancy and childbirth) and this could have, or did impact on their death, you should make that clear to the organisation. They do not have to agree with you, but they do have to explain their response. **Sands have produced a document** to help you understand how you can raise concerns or make a complaint about your care.

A patient safety incident investigation is conducted by trained investigators within the organisation, using a range of tools to thoroughly understand what happened and why it happened. Such investigations do not decide the cause of death and are not intended to decide if someone is to blame for a death. They help NHS organisations learn how to reduce the risk of harm happening again.

What happens during an NHS Patient Safety Incident Investigation?

You have the right to be informed and involved in the process from the beginning and throughout, and to see the final report. The investigation should take no longer than 6 months to complete but may take longer if the issues are complex.

For babies who were born at term (37 weeks gestation or over), and were alive at the start of labour, but died within the first week of life the serious incident investigation will be the responsibility of the Maternity and Newborn Safety Investigation (MNSI) Programme. This is an external investigation, which means it is not carried out by the hospital where your baby died. A MNSI investigation will only take place if you consent to it. Otherwise, your baby's death will be investigated by the hospital where your baby died using the PSII. You have the right to be involved in both the MNSI or PSII investigation.

At the end of the investigation a report will set out what happened and why (as far as possible, depending on the evidence available) and make recommendations for any future action that the NHS organisation should take to reduce the risk of harm in the future. This report should be shared with you and a meeting arranged with hospital staff to go over it and answer any questions you have or explain anything you don't understand.

This link provides more information on **The Patient Safety Incident Response Framework**

You can find more information about **MNSI investigations on their website**

The conclusion of the Child Death Review

Review of the death of a baby soon after birth

To improve the quality of the reviews of the deaths of babies who die soon after birth, a tool called the national **Perinatal Mortality Review Tool** (PMRT) has been developed. The PMRT is designed so that a high quality, standardised review of care of the mother during pregnancy and childbirth, and the care of the baby after birth is carried out. The PMRT is an interactive, web-based tool which guides the review process to ensure that all aspects of care are considered and are reviewed against national guidelines and standards.

The review is led by the hospital where the baby died and identifiable information is used in the PMRT. The report of the review produced by the PMRT is included in medical records and used as the basis of the discussion at the follow-up meeting with the parents.

Local discussions about your child's death – the Child Death Review meeting

A final meeting will take place between the different professionals who were involved in your child's care both before and after your child died. The purpose of this meeting is to review all the information to understand why your child died and to identify any learning that may prevent future child deaths. A report of the meeting is sent to the local Child Death Overview Panel (see page 14).

The nature of this meeting, and which professionals are involved, will vary depending on the circumstances of your child's death. It may be referred to by a number of different names, including 'final case discussion', 'hospital mortality meeting' if your child died while they were in hospital, or a 'perinatal mortality review meeting' in the case of perinatal deaths.

You should be offered an opportunity to put questions to the meeting by your key worker. Afterwards you should also be offered a meeting with an appropriate senior member of staff to discuss any outcomes as well as get feedback on any questions you have raised. This meeting could be with a consultant paediatrician, neonatologist, obstetrician or senior health professional. Your key worker can help to arrange these meetings.

Regional discussions about child deaths – the Child Death Overview Panel

What is a Child Death Overview Panel?

This is a multi-agency panel (referred to as a Child Death Overview Panel (CDOP)) that looks at all child deaths in a wider context than the earlier stages of the review, which would have considered your child individually.

The deaths of all children under the age of 18 must be reviewed by a CDOP. There are a number of panels around the country, and your child's death will usually be considered by the panel local to where your child lived. CDOPs are groups of professionals who meet several times a year to review all the child deaths in their area. The panel is not given the names of any children who died or any information that might make the report identifiable; all the details are dealt with anonymously. Their main purpose is to learn from these deaths to try and prevent future deaths.

By law all child deaths should be reviewed to try to prevent future deaths where possible

Although the panel will not include the professionals who were involved in your child's care, they will receive a report from the professionals who were involved

The CDOP makes recommendations and reports about the lessons learned to those responsible at a local level. They do not produce reports about the death of individual children, but each CDOP produces an annual report which is a public document. Anyone can read the annual report, but it does not contain any details that could identify an individual child or their family.

Who is on the panel?

The Panel has representatives from:

- public health
- local child health
- social care services
- the police.

Other professionals may be invited to give specialist advice where needed.

Can you be involved in the Child Death Overview panel?

Families are not invited to be part of the panel or to be involved in the discussion of their child's death at this stage. The panel meeting discusses many deaths at each meeting and all identifiable information relating to your child or any professionals involved is anonymized. Because of the anonymous nature of the panel review, it is not possible to give you specific feedback from this meeting. If you have any information concerning your child's death which you think might inform the meeting this can be submitted to the CDOP administrator via your key worker.

National Child Mortality Database (NCMD)

The National Child Mortality Database receives information from CDOPs on all children in England who die before their 18th birthday. Its role is to perform detailed analysis and interpretation of this information. Collecting this information will ensure that deaths are learned from, that learning is widely shared, and that actions are taken, locally and nationally, to reduce preventable child deaths in the future. **More information on NCMD is available here**.

If the Child Death Review Process has not been followed

Sometimes the processes that are in place may not happen as they should, and it can be difficult to bring this up, particularly given that the different elements of this guide will not apply to all deaths.

If you feel you have not been kept informed about what is happening at any point in the review of your child's death, you should first contact your key worker. You could also contact another professional who has been supporting you, or a charity or other organisation who can offer support. If you don't have anyone you can call, please turn to the information and bereavement support sections at the end of this guide.

Your key worker should be your first point of contact

If you are not sure who your key worker is, or you have not been allocated a key worker, contact a named professional who you do have details for. This may be from a hospital, hospice, police or coroner's office.

Part 2

Things for you to do

This section covers some of the different things you may need to do yourself. Where you don't feel able to do them yourself, you may want to think about asking someone to help you.

Support

The initial days, weeks and months following your child's death are extremely difficult. Whatever your thoughts and feelings, grief is a personal experience and has no set time or process. There is no right or wrong way to grieve.

Registering your child's death

You will need to register your child's death by making an appointment and then attending a register office. If you have not already registered your baby's birth you will also need to do this – there is a requirement to register the birth within 42 days of birth. It is up to you whether you choose to do both during one visit. If you have been issued with a Medical Certificate of Cause of Death, then you must register your child's death. - There is a requirement to register within five days of the death. You should have been given information with the certificate about where the death should be registered. If this is not convenient, other options are available such as making a declaration more locally; the register office can provide more advice if required.

If your child's death has been referred to the coroner, then there may be a delay in your being able to register their death. You can register your child's death as soon as the coroner has issued a form 100A which confirms that the death can be registered. In some cases, the coroner may first order a post-mortem examination, and where the coroner no longer requires further investigations, they will send a Form 100B (called the 'pink form') to the registrar. If there is going to be an inquest, the coroner will report directly to the register office following the inquest and the registrar will then register your child's death. Once your child's death has been registered, you will be able to obtain a death certificate.

Planning your child's funeral

You can start to plan the funeral at any time, but you can only hold it once you have the death certificate or appropriate form from the coroner. If you have religious or other requirements that may affect the timing of your child's funeral, please discuss these with hospital staff or your key worker as soon as possible. They will alert the coroner if a coroner is involved. Although it may not be possible, the coroner will try to accommodate your wishes.

You may wish to discuss possible choices with your chosen funeral director. Take time to consider what would be most meaningful for you and your family. The costs of burials and cremations vary and there are other expenses that you may not have considered, so you should ask for a written estimate before finalising the arrangements.

If you are on a low income, you may be eligible for a '**Funeral Expenses Payment'**, which your funeral director should be able to help you find more information about. The **Children's Funeral Fund** for England can help to pay for some of the costs of a funeral for a child under 18 or a baby stillborn after the 24th week of pregnancy. It is not means-tested: what you earn or how much you have in savings will not affect how much you get. The fund can help pay for burial fees, cremation fees (including the cost of a doctor's certificate), coffin, shroud or casket (up to £300). If you have other funeral expenses, you might be able to apply for a Funeral Expenses Payment.

Child benefit and other payments

If you have received benefits for your child, either in payments or equipment, these will usually continue for some weeks after your child has died, but the timing differs for different types of benefits. It is up to you to contact the agencies that provide your benefits, and it is a good idea not to delay this or you may be overpaid and must repay any overpayments. The government provides information on this on their **website.**

Child benefit is paid for up to eight weeks after a child dies, but you will need to ensure that you have told the child benefit office that your child has died. You can do this by phone or by post. You can find out more about this **here on their website**.

Contacting these agencies can be difficult to do, so it might be a task you ask someone to help you with.

Other things to consider

Your child's GP and school or college should have been notified of your child's death by a healthcare professional very quickly, but some families contact them directly as well. You could ask your GP to add a flag on your and your family's records about your child's death so that you do not have to explain what happened at each visit.

There may be other places that have your child's details such as banks and building societies, local groups, religious organisations, clubs, dentist and opticians that you will need to inform at some point. If you joined any baby or child groups, such as supermarket clubs or online clubs, you would need to tell them that you don't want to receive any more information. Otherwise, you may continue to be contacted with offers and information about your child's expected progress. The Mailing Preference Service can help with this; **you can register online here**.

You may wish to reconsider your privacy settings on social media if there are photos of your child on there, as these could be reused without your permission if they are publicly accessible. If your child had their own social media accounts, you can either deactivate them, turn them to a 'memorialised' account or leave them as 'live' accounts. To change the accounts, you will need to provide proof of your relationship and your child's death certificate to the social media provider.

Returning to employment might not be something you can consider at this stage. **Paid leave for bereaved parents** entitles you and your partner to take up to two weeks of leave in the year following the death of your child, but your work may also make their own decision about compassionate leave. You can self-certify sickness absence for the first week, and then you will need to visit your GP for a 'fit note' to continue to take sick leave. Try to contact your work, or ask someone else to, if you need more information about your employer's position and your right to paid leave.

Emotional support is available for you, and your wider family, including any other children you have. The bereavement support organisations listed at the end of this guide are open to you and your family at any point, even if you already have support through a hospital or hospice. Bereavement support is available in several different ways, whether you feel most comfortable calling or you would prefer to email, connect online or meet face-to-face.

If you need immediate support at any time, the **Samaritans** are open at every hour of the day by phoning **116 123**.

Where to go for more information

The Child Death Review Process is set out in detail in Child Death Review – operational and statutory guidance for professionals. You may wish to look at this if you would like more detail about the process.

Coroners' Courts Support Service

A voluntary support organisation that provides emotional and practical support to families attending an inquest at a coroner's court. You can **find out more information on their website here**.

Post-Mortem Examinations

The NHS provides online information about post-mortem examinations and where to get more detailed information. You can **find out more on their website here**.

Sources of bereavement support

You should be offered support and signposted to local services and organisations you might find helpful to contact. The following national organisations can also offer support and advice. All these organisations offer bereavement support to families, but we cannot recommend any. You might also want to look at the **National Bereavement Alliance** which sets standards that some of these organisations work towards. These are suggested contacts:

Bliss

Information and support for families of babies born premature or sick.

www.bliss.org.uk
020 7378 1122
hello@bliss.org.uk

Care for the Family – Bereaved Parent Support

Peer support for any parent whose son or daughter has died at any age, in any circumstance and at any stage in their journey of grieving.

https://www.careforthefamily.org.uk
029 2081 0800
mail@cff.org.uk

Child Bereavement UK

Supports families and educates professionals when a baby or child dies or is dying, or when a child is facing bereavement.

www.childbereavementuk.org
0800 02 888 40
helpline@childbereavementuk.org

Child Death Helpline

For anyone affected by the death of a child of any age from any cause.

www.childdeathhelpline.org.uk
0800 282986

The Compassionate Friends

Support for bereaved parents and their families.

www.tcf.org.uk
0345 123 2304
helpline@tcf.org.uk

The Lullaby Trust

Support for anyone affected by the sudden and unexpected death of a baby or young child.

www.lullabytrust.org.uk
0808 802 6868
support@lullabytrust.org.uk

SUDC-UK

Supports any family whose child, aged between 1 and 18 years, has died suddenly and with no immediately apparent cause.

www.sudc.org.uk
07880 350942
info@sudc.org.uk

Sands

Support for anyone affected by the death of a baby.

www.sands.org.uk
0808 164 3332
helpline@sands.org.uk

A Child of Mine

Provides emotional and practical support for bereaved families.

www.achildofmine.org.uk
01785 785 819
hello@achildofmine.org.uk

Twins Trust

Support for anyone affected by the death of a multiple.

https://twinstrust.org/bereavement.html
0800 138 0509
enquiries@twinstrust.org

2Wish

Provides immediate and ongoing support to anyone affected by the sudden death of a child or young person up to the age of 25.

www.2wish.org.uk
01443 853125
info@2wish.org.uk

There are also several useful organisations who hold information about the many smaller, specialised and local organisations available for bereaved families.

You may be able to find an organisation that focuses on your situation more specifically through one of those listed below, where you can search for bereavement support which is specific to your situation. They also list details of other charities that can support you:

The Childhood Bereavement Network

Supports bereaved children and young people

www.childhoodbereavementnetwork.org.uk

At A Loss

The UK's bereavement signposting and information website

www.ataloss.org

The Good Grief Trust

Features video stories and articles from other families who have lost a child, both at a young age and in adulthood and shares initiatives from the professionals who support them

www.thegoodgrieftrust.org

Sponsorship Logos

NHS England

The National Child Mortality Database (NCMD) **is an NHS England funded program**

NCMD
National Child Mortality Database