Bereavement Outcomes Framework

Standard	*All staff in all agencies and organisations have a duty to support bereaved parents and carers after their child's death and to show kindness and compassion*[1]*.* *Parents should be informed by their key worker that the review at CDOP will happen, and the purpose of the meeting should be explained. CDOPs should assure themselves that the information provided to the panel provides evidence that the needs of the family, in terms of follow up and bereavement support, have been met*[2]*.*	
Process	**Immediate/ Joint Agency Response**	*When their child dies, bereaved parents or carers should:* *• have the opportunity to spend time with the child's body in a quiet and private environment;* *• have the opportunity to make memories including taking photographs, hand and footprints and a lock of hair;* *• (if the parents or carers wish) expect a member of staff to remain with them, to provide comfort, and to ensure their basic needs are met;* *• be given the contact details of their key worker and the identity of their medical lead, be informed who will be contacting them and when they will be contacted after they leave the hospital or hospice (and what to do should they have any questions in the meantime);* *• know how to make arrangements to view their child's body;* *• be given information on death registration and the coronial process (if applicable);* *• understand why a post-mortem examination may be indicated and, if so, where it is taking place, and when the results might be expected. In the event of a coroner's case this responsibility falls to the coroner's officer;* *• be supported to have an understanding of the child death review process and how they are able to contribute to it;* *• be given practical advice in respect to organising the child's funeral*; *• have the key worker accompany them to meetings to provide practical and emotional support; and* *• be able to access expert bereavement support if required*[3]
	Child Death Review/ Inquest	*Parents should be informed of the Child Death Review meeting by their key worker and have an opportunity to contribute information and questions through their key worker or another professional. At the meeting's conclusion, there should be a clear description of what follow-up meetings have already occurred with the parents, and who is responsible for reporting the meeting's conclusions to the family*[4]*.*
	Key worker (navigator not counsellor)	*1.Time. How much time will be needed for the role may vary greatly from case to case.* *2.Team support. Families should expect to be able to contact the key worker or a team member during normal working hours.*

[1] *HM Govt (2018) Child Death Review Statutory Guidance.* p39
[2] *HM Govt (2018) Child Death Review Statutory Guidance.* pp37-38
[3] *HM Govt (2018) Child Death Review Statutory Guidance.* p41
[4] *HM Govt (2018) Child Death Review Statutory Guidance.* p31

		3.Individual support. Working with bereavement can be stressful. The key worker and their line manager should agree a plan to ensure that they are appropriately supported in the role, including opportunities for debriefing and supervision[5].	
	CDOP	*Parents should be assured that any information concerning their child's death which they believe might inform the meeting would be welcome and can be submitted to the CDOP administrator. CDOPs should assure themselves that the information provided to the panel provides evidence that the needs of the family, in terms of follow up and bereavement support, have been met*[6].	
	Beyond CDOP How do we do this?	Gaining feedback from families, key worker check in 1 year, letter from CDOP chair Themes[7] • Last moments shared • Compassionate care • Supportive environment • Compassionate communication • Personalised care • Bereavement care and support • Child death review • Learning culture	
Outcomes	Family	Immediate	Receive information, have key worker contact, relevant agencies support in finding answers[8]
		First 6 months	Key worker contact, able to talk and be listened to, signposting[9] to bereavement counselling
		Over time	Access to bereavement support or counselling, gather feedback from families[10]
	Peers	Have had opportunity to be heard and have continued access to bereavement counselling	
	Community	Have had opportunity to share worries about cause of death	
Commissioning bereavement support	Bereavement counselling / Support networks	Families have opportunity to have bereavement support from; for example: Hospice, Cruse Bereavement Support, Child Bereavement UK, Compassionate Friends, SANDS, Winston's Wish	

[5] HM Govt (2018) *Child Death Review Statutory Guidance*. p64
[6] HM Govt (2018) *Child Death Review Statutory Guidance.* p37
[7] Healthy London Partnership (2019) *Gathering feedback when a child dies*
[8] https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/
[9] HM Govt (2018) *Child Death Review Statutory Guidance*. Appendix 7 – Bereavement resources
[10] Healthy London Partnership (2019) *Gathering feedback when a child dies*