NHS Borders

Woman and Children's Service

Title	**Children & Young Person Death Review Process**
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Contents Page

INTRODUCTION

1.1 The Scottish Government through the commissioning of the National Hub for Reviewing and Learning from the Deaths of Children and Young People (co-hosted by Health Improvement Scotland and the Care Inspectorate) require us to standardise and streamline the way in which we review, record and report all Child and Young Persons deaths within NHS Borders. (Aged 0-18 or up to the age of 26 if in receipt of ongoing care or aftercare in local authority care). This Data will be collated and inputted into the National Hub's Online Portal.

1.2 The outcome of these reviews should present some key findings allowing for leaning and development that may assist in the prevention or reduction of the deaths of children and young people. This will be a multiagency approach and collaboration with other NHS Boards and Local/National Authorities can be essential. Inclusive of Healthcare Improvement Scotland and the Care Inspectorate.

1.3 There has been a Child Death Review team established within the Borders General Hospital to maintain this service – the team will closely link in and communicate with other review groups in the Scottish Borders.

1.4 This SOP has created a process in line with the National Hub Guidance for managing Child and Young Person Death Reviews.

1.5 Different review processes exist below, each of these processes will support the CDR final report.

1. Child Death Review (Children aged 2-18 years)
2. Perinatal Mortality Review (under 28 days) (PMRT)
3. SUDI (Sudden Unexplained Death in Infancy) -sudden unexpected death <2 years)
4. Drug Death Review Group
5. Sudden Death Review Group (actions relating to deaths by suicide in the Scottish Borders
6. Care Experienced Young People – 16 -26 years who are still in receipt of care or after care.
7. Learning Reviews – Child Protection.
8. SAER Review
9. Adult Review - inc Global Trigger Tool, Structured Review & Mortality & Morbidity Review.

1.6 There will be a Lead identified for each review, linking in with appropriate agencies to ensure a quality review takes place.

2.0 RELATED DOCUMENTATION

2.1 Datix
2.2 Parent Letters
2.3 Patient Medical Notes/TRAK/EMIS
2.4 Any additional patient related reviews e.g. SAER
2.5 Feedback from multiagency reports
2.6 Core Data Set
2.7 Leaning Outcomes
2.8 Bereavement Leaflets
2.9 CDR Parent Support Information Leaflet

3.0 MEMBERS OF THE CHILD DEATH REVIEW TEAM

- Clare Ketteridge – Paediatric Consultant/Clinical Lead CDR
- Shona Finch - Clinical Nurse and Midwifery Manager/CDR Lead
- Ailie Ramage – Paediatric Staff Nurse/Project Manager CDR
- Laura Jones - Head of Quality and Clinical Governance
- Joanne Forrest, Clinical Risk Coordinator
- Eileen Mc Dermott – Group Manager Child Protection and Duty Assessment
- Susan Elliott – ADP Coordinator - Drug Death Review Group
- Ruth Ashman–Consultant Psychiatrist CAMHS
- Susan Balfour – Police Scotland
- Rachel Pulman- Nurse Consultant for Public Protection (child and adult)

4.0 PROCEDURE

4.1 Pathway Management Flowchart

The following pathways are to use as a guide. Each review will be specific and individually considered, the clinical lead may choose to modify the pathway in order to best suit the circumstances of each case review.

	Pathway	Age of child
1	Neonatal Death in Hospital	0-28 days
2	Sudden Unexpected Death of an Infant (SUDI)	<2years
3	Sudden Unexpected Death of a Child in the Community	2-16 years
4	Child Death in Hospital – Unexpected	0-16 years
5	Child Death – Expected	0-16 years
6	Death of a Young Person – Expected/Unexpected	16-18 years 18-26 years LAC
8	Death of a NHS Borders Child/Young Person out with a NHS Borders Locality – Unexpected/Expected	0-16 years 16-18 years 18-26 years LAC
9	Death of a 'Holiday patient' in the NHS Borders Health Board	0-16 years 16-18 years 18-26 years LAC

Neonatal Death in Hospital	0-28 days

Baby dies during hospital admission

Parents provided with bereavement box and leaflet about available support.

Paediatric consultant/Health Professional completes Datix

Case discussed at next CDR Meeting.

PMRT link invited.

Appropriate Lead Reviewer is identified.

CDR Team send follow-up parent letter and support leaflet on day 42 inviting parents to attend meeting with Paediatric Consultant.

Parent accepts invitation

Parents attend post –event meeting with Paediatric Consultant +/- CDR Lead. Next steps identified as:
Summary letter of meeting
Details of CDR/PMRT review meeting

Parent declines invitation or does not respond

CDR Team send follow up parent letter on day 84 re issuing invitation to meet, but also noting:
Details of CDR/PMRT review meeting
Promise of summary report.

Paediatric Consultant +/- CDR Lead host review meeting and approves Data Set.

Data set to be sent to National Hub Online Portal/ Copy for Medical Notes and added to DATIX.

Inform:

-Primary Care team/GP
-Child Protection Health Admin
-Hospital Bleep Holder
-Communications Team (if media interest likely and/or public comms req'd)

IMPORTANT
Debrief

'Hot Debrief' - on the same day of event where possible.

'Second Debrief' - within 7 days of event where possible.

'Peer Review' – next available teaching session

A SAER will be considered in all unexpected deaths. If commissioned, a copy of the report will be sent to CDR Team on completion.

Sudden Unexpected Death of an Infant (Community)	< 2years

A SAER will be considered for all unexpected deaths. If commissioned, a copy of the report will be sent to CDR Team on completion.

Transferred to BGH ED
FOLLOW SUDiC GUIDELINES FOR MANAGEMENT IN ED
W:\Ward 15\BGH SUDiC Guideline 2018 (002).pdf

Inform:

-Police (if not already aware)
-Procurator Fiscal
- Primary Care team/GP
-Child Protection Health Admin
-Hospital Bleep Holder
- IRD Discussions
Communications Team (if media interest likely and/or public comms req'd)-

Parents provided with bereavement box and Leaflet about available support.

Paediatric Consultant completes IRD as per SUDiC Guidelines

Paediatric Consultant/Health Professional completes Datix

Case discussed at next CDR Meeting

Invite PMRT link if <28/7

Appropriate Lead Reviewer identified

Debrief:
IMPORTANT
Debrief
'Hot Debrief' - on the same day of event where possible.

'Second Debrief' - within 7 days of event where possible.

'Peer Review' – next available teaching session

CDR Team send follow-up parent letter and support leaflet on day 42 inviting parents to attend meeting with Paediatric Consultant.

Parent accepts invitation.

Parent declines invitation or does not respond.

Parents attend post –event meeting with Paediatric Consultant +/- CDR Lead. Next steps identified as:
Summary letter of meeting
Details of CDR/SUDI review meeting
Promise of Review report

CDR Team send follow up parent letter on day 84 re issuing invitation to meet, but also noting:
Details of CDR/SUDI review meeting
Promise of summary report.

Paediatric Consultant +/- CDR Lead host review meeting and approves outcome SUDI report and Data Set.

Outcome SUDI report to be sent to HIS and a Copy for Medical Notes.

Data Set to be sent to National Hub online Portal/ Copy for Medical Notes and added to DATIX.

Sudden Unexpected Death of a Child (Community)	2-16yrs

A SAER will be considered for all unexpected deaths. If commissioned, a copy of the report will be sent to CDR Team on completion.

Transferred to BGH ED
FOLLOW SUDiC GUIDELINES FOR MANAGEMENT IN ED
W:\Ward 15\BGH SUDiC Guideline 2018 (002).pdf

Inform:
-Police (if not already aware)
-Procurator Fiscal
- Primary Care team/GP
-Child Protection Health Admin
-Hospital Bleep Holder
-Pathology Department
- IRD Discussions
- Communications Team (if media interest likely and/or public comms req'd)

Parents provided with bereavement box and Leaflet about available support.

Paediatric consultant completes Datix

Paediatric Consultant completes IRD as per SUDiC Guidelines

Case discussed at next CDR Meeting

Appropriate Lead Reviewer identified

Debrief:
IMPORTANT
Debrief
'Hot Debrief' - on the same day of event where possible.

'Second Debrief' - within 7 days of event where possible.

'Peer Review' – next available

CDR Team send follow-up parent letter and support leaflet on day 42 inviting parents to attend meeting with Paediatric Consultant.

Parent accepts invitation.

Parent declines invitation or does not respond.

Parents attend post –event meeting with Paediatric Consultant +/- CDR Lead. Next steps identified as:
Summary letter of meeting
Details of CDR/ meeting
Promise of Review report

CDR Team send follow up parent letter on day 84 re issuing invitation to meet, but also noting:
Details of CDR meeting
Promise of summary report.

Paediatric Consultant +/- CDR Lead host review meeting and approves CDR report and Data Set.

Data Set to be sent to National Hub Online Portal/ Copy for Medical Notes and added to DATIX.

Child Death in Hospital – Unexpected	0-16 years

A SAER will be considered in all unexpected deaths. If commissioned, a copy of the report will be sent to CDR Team on completion.

Child dies during hospital admission. Incident unexpected

Inform:

-Procurator Fiscal
- Primary Care team/GP
-Child Protection Health Admin
-Hospital Bleep Holder
- IRD Discussions
- Communications Team (if media interest likely and/or public comms req'd)

Parents provided with bereavement box and Leaflet about available support.

Paediatric consultant/Health Professional completes Datix

Paediatric Consultant completes IRD as per SUDiC Guidelines

Case discussed at next CDR Meeting

Appropriate Lead Reviewer identified

Debrief:
IMPORTANT
Debrief
'Hot Debrief' - on the same day of event where possible.

'Second Debrief' - within 7 days of event where possible.

'Peer Review' – next available teaching session

CDR Team send follow-up parent letter and support leaflet on day 42 inviting parents to attend meeting with Paediatric Consultant.

Parent accepts invitation

Parent declines invitation or does not respond

Parents attend post –event meeting with Paediatric Consultant +/- CDR Lead.
Next steps identified as:
Summary letter of meeting
Details of CDR/SUDI review meeting

Paediatric Consultant +/- CDR Lead host review meeting and approves outcome SUDI report (if relevant) and Data Set.

Outcome SUDI report to be sent to HIS and a Copy for Medical Notes.

Data set to be sent to National Hub online Portal/ Copy for Medical Notes and added to DATIX.

CDR Team send follow up parent letter on day 84 re issuing invitation to meet, but also noting:
Details of CDR/SUDI review meeting
Promise of summary report.

Child Death - Expected	0-16 years

Child dies following planned end of life

Anticipatory care plan in place

Parents provided with bereavement box and Leaflet about available support.

Paediatric Consultant/Health Professional to complete Datix

Case discussed at next CDR

Invite palliative care team and lead consultant

Meeting and appropriate Lead Reviewer is identified

Inform:
- Primary Care team/GP
-Child Protection Health Admin
-Hospital Bleep Holder
-Communications Team (if media interest likely and/or public comms req'd)-

Debrief:

IMPORTANT
Debrief
'Hot Debrief' - on the same day of event where possible.

'Second Debrief' - within 7 days of event where possible.

'Peer Review' – next available teaching session

CDR Team send follow-up parent letter and support leaflet on day 42 inviting parents to attend meeting with Paediatric Consultant.

Parent accepts invitation

Parent declines invitation or does not respond.

Parents attend post –event meeting with Paediatric Consultant +/- CDR Lead. Next steps identified as:
Summary letter of meeting
Details of CDR/SUDI review meeting

CDR Team send follow up parent letter on day 84 re issuing invitation to meet, but also noting:
Details of CDR/SUDI review meeting
Promise of summary report.

Paediatric Consultant +/- CDR Lead host review meeting and approves Data Set.
Data set to be sent to National Hub Online Portal/ Copy for Medical Notes and added to DATIX.

Death of Young Person Expected / Unexpected	16-18 years 18-26yrs LAC

Notification of death may be received from:

- Emergency Department/Wards BGH
- Via multiagency colleagues e.g. police/Social Work
- Via separate review processes e.g. Drug Death reviews
- Monthly report generated from General Registers Office/ Datix / Trak of all deaths aged 0-26yrs

This can be done via email to BOR.childrensreviews@borders.scot.nhs.uk or by contacting the CDR Lead.
Please contact Communications Team (if media interest likely and/or public comms req'd)

Case discussed at next CDR Meeting.

Relevant professionals invited

Appropriate Lead Reviewer is identified – Regular updates with CDR Group to be established See below

Child Death Review

Sudden death review

Drug death review

Speciality e.g. ITU

SAER

CDR Team send follow-up parent letter and support leaflet on day 42 inviting parents to attend meeting with Paediatric Consultant.

Accepts

Declines/no response

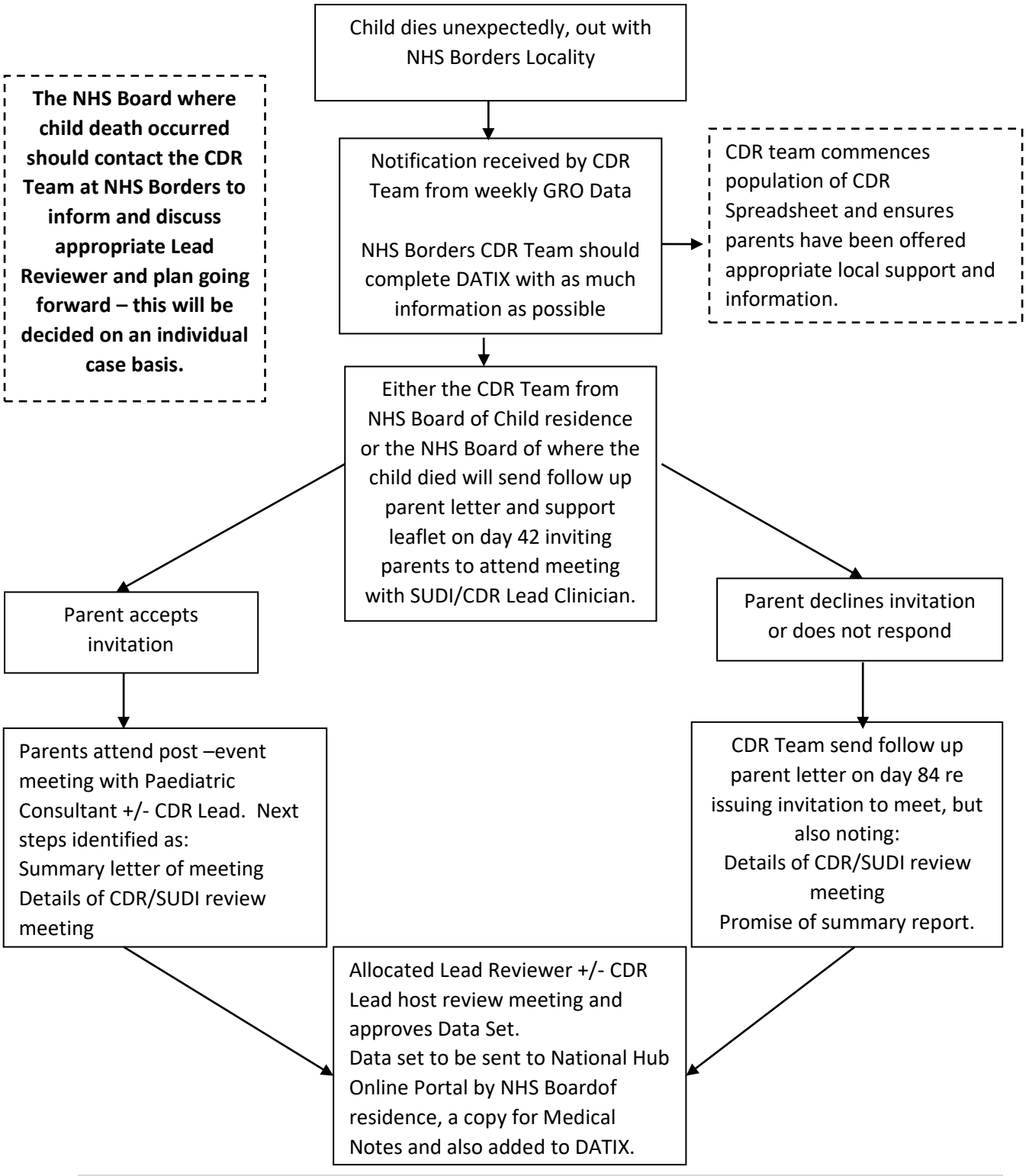
Parents attend post – event meeting with Paediatric Consultant +/- CDR Lead. Next steps identified as:
Summary letter of meeting
Details of CDR/SUDI review meeting

CDR Team send follow up parent letter on day 84 re issuing invitation to meet, but also noting:
Details of CDR/SUDI review meeting
Promise of summary report.

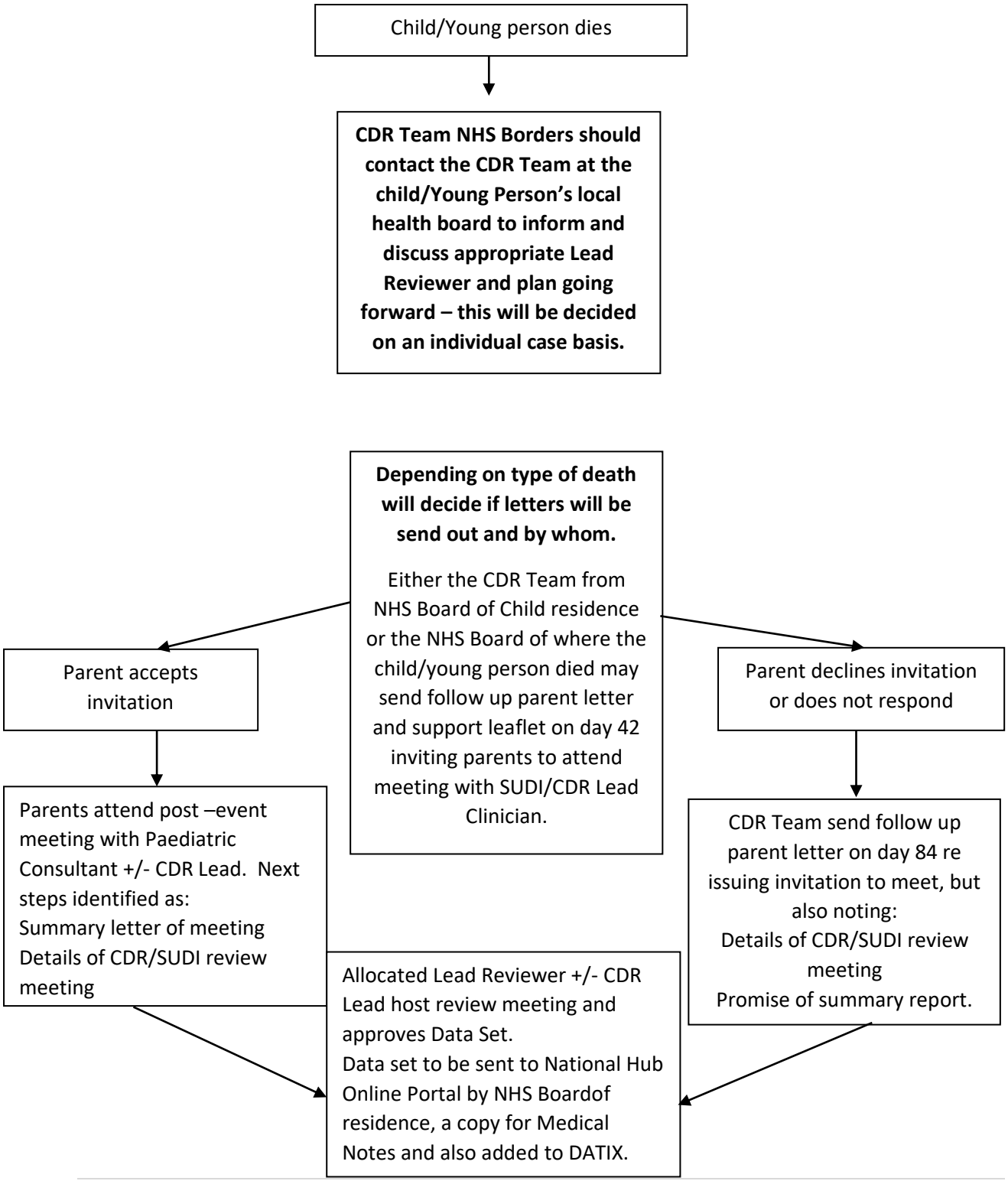
Paediatric Consultant +/- CDR Lead host review meeting and approves Data Set.
Data set to be sent to National Hub Online Portal/ Copy for Medical Notes and added to DATIX.

Data set to be completed by appropriate review group and CDR Team to submit to National Hub Online Portal and a Copy for Medical Notes and added to DATIX.

Death of a NHS Borders Child out with NHS Borders Locality	0-16 years 16-18 years 18-26 LAC



Death of a 'Holiday patient' in the NHS Borders Health Board	0-16 years 16-18 years 18-26 years LAC



5.0

Stage 1 – Initial Reporting and Notification

- **< under 16**
- Paediatric Consultant is notified in ALL cases
- Notifications can be received from ED/SAS/Police
- In all unexpected deaths IRD is generated.
- All deaths to be reported on DATIX. This can be done by any professional involved at the time of death i.e. Consultant/Nurse practitioner/Nurse
- Consider if SAER is indicated.
- Email Child Death review Team to notify – BOR.childrensreviews@borders.scot.nhs.uk
- Contact Communications team as soon as possible, if there are any concerns regarding possible media coverage. E.g. Public Health concerns, suicide, unexplained death.

- **16-18 years/ 18-26 years LAC**
- Notifications may come from ED/SAS/Police/Local Authority
- All deaths to be reported on DATIX this can be done retrospectively.
- Email Child death review team to notify – BOR.childrensreviews@borders.scot.nhs.uk
- Consider if SAER is indicated.
- Contact Communications team as soon as possible, if there are any concerns regarding possible media coverage. E.g. Public Health concerns, suicide, unexplained death.

- Monthly report generated from General Registers office/DATIX/TRAK of all deaths aged 0-26years.

- CDR team will add details to CDR Spreadsheet and create IC (Initial Checklist) Form.
- CDR team will add to Agenda for next Child Death Commissioning Meeting.

5.1

Stage 2 - Assessment – Determining the appropriate review

1. Type of review to be decided by CDR Team via email/teams
2. Relevant staff invited to CDR commissioning meeting where possible.

Different review processes below

- **Perinatal Mortality Review**
- **Sudden Unexpected Death in Infancy (SUDI)**
- **Care experienced child or young person**(including 18-26 years in continuing care or after care).
- **Significant Adverse Event Review**
- **Drug Death Reviews**
- **Sudden Death Review Group (SBDSRG/DSRG)**

- National Guidance for Child Protection Committees Undertaking Learning Reviews
- Adult Review NMCRR guide England_0.pdf (rcplondon.ac.uk)
- Mortality and Morbidity Reviews 20171128_Mortality_and_morbidity_reviews_HIS.pdf
- **Child Death Review** – for all deaths of children or young person up to their 18th birthday that do not fit into any of the above categories.

3. Decide the appropriate CDR process (es) and clarify time frame for review. If the case requires an SAER, this will be decided by clinical Leads/management.
4. Ensure the report from any other review team is received prior to the CDR meeting for the team to discuss.

5.2

Stage 3 – The Review (a)

1. Appropriate review choice has been established.
2. Highlight which professionals and gather information from those involved in the Child/Young Person's professional care.
3. CDR team collates information from child/young person's records and ensures Multiagency involvement and Information Gathering reports.
4. Arrange meeting with professionals' team (note time limiter may be the receipt of the post mortem report).
5. Conduct meeting
6. Enter draft meeting outcomes on Core Data Set Report
7. Share draft Core Data Set Report with everyone that was present – on request.
8. Once approved forward to National Hub.

Prior to the meeting

9. Decide on who should lead/chair the meeting and who should attend.
10. Who will be the key worker liaising with the family and providing feedback after the meeting.
11. Ensure that all reports from professionals have been received prior to the meeting – especially if not all can attend.
12. If an SAER has been commissioned if would be useful to have this report prior to the meeting and forwarded to relevant health professionals.
13. Ensure appropriate notice given.
14. Ensure parents are informed of meeting– parents invited to contribute questions/any comments that they would like discussed at the meeting via key worker.
15. Secure appropriate Venue –or on Microsoft Teams.

16. Existing review processes should continue to run with the principles above to be incorporated – **only one overall review process should be held** ensuring the national data set completed.

The Review meeting

The Meeting

1. Formulate and distribute the Agenda
2. Welcome and introductions by Chair
3. Define purpose of meeting
4. Discussion of the circumstances of the death
5. Chronology of Events – at this point invite attendees to discuss any interactions their agency had with the child and their family during their life
6. Discussions of questions that family may have
7. Discussion of conclusions with recommendation and learning points.
8. Completion of Dataset.
9. Completion of Report
10. Consider summary letter to parents with invitation to meet with Key worker if family wish.

Stage 3 – The Review (b) closing the child death review and DATIX

1. Completed CDR paperwork will be stored in the Medical Notes and attached to DATIX form.
2. CDR Team approves to close DATIX (PM results can be added at a later date).
3. Ensure completed Data Set is fully completed with the support of Multiagency involvement and upload data to the National Hub's Online Portal, a copy can also be added to medical notes and attached to DATIX.
   (Please note until online portal is up and running – complete PDF data set and save in secure drive, copy in patient medical records and attach to DATIX)

5.3

Stage 4 – Improvement planning and monitoring.

- Identify any "learning points" or "actions"necessary to be investigated.
- Learning points/Actions will be documented and shared at the Child Health Business Meeting and Child Protection Delivery Group for discussion.
- Add learning points to open Datix
- Annual board report to clinical governance committee.
- Feedback to Staff

5.4

Parent Liaison Support

1. A (Recorded Delivery) letter should be sent to the parent(s) from either Clinical Lead or CDR Team on day 42 noting the following:
    - Condolence
    - Identification of a person of contact
    - Invitation to meet.
    - Contact number and email address
    - Notification regarding review process and estimated timescales.
    - Child bereavement UK leaflet.

A **Day 42** Letter template has been added to appendices, please note this is a guide only and may be individualised by the clinical lead.

Please note if no response to **Day 42** letter, A **Day 84 Unable to reach** letter should be sent out to the parents/carers.

Initial Meeting

- Family welfare check
- Encourage any questions relating to the child's death
- Ensure bereavement support has been offered and is still in place if required
- Child death information update (for example pathology)
- Inform of child death process including timescales, and update.
- Admin update database noting meeting has occurred along with date and time.

Follow up letter

- Follow up letter to parent/carer to be sent out following initial meeting.

Review Meeting Letter

- Letter to parent noting CDR date and that update will be sent out by letter.
- Admin update database noting meeting has occurred along with date and time.

Post Review/Report Letter

- Letter to be sent to parent with CDR outcome and invitation to meet
- Meeting (if parents wish)

5.5 The Allocation and Commissioning CDR Meeting

This Meeting will meet monthly – the last Thursday of every month 3-4pm to consider all child and young people deaths and ongoing reviews.

Routine attendance is expected by:

CDR Clinical Lead
PMRT Clinical Lead
Public Protection Link
CDR Project Manager
Clinical Governance Patient Safety
Invited Clinical Links
Invited Local Authority

This meeting will summarise all new deaths that have been reported in the previous 4 weeks and any further information that may have been noted in this time. It will also review all open cases and a chronological update provided by the clinical lead is expected.

A discussion will then take place which will focus on a summary of events of each new death and identification of the most appropriate lead.

Once agreed who is going to undertake the review, this information should be shared and documented into the current child/young person death database and Initial Checklist Form.

5.6 Health Board Partnership Review

Children from another health board who die within NHS Borders

- When a notification is received of the death of a child who resides within a different NHS Health Boards area, the CDR Team will immediately notify the home NHS Health Board of the event.
- The Home NHS Health Board of the child will be expected to allocate a clinical lead reviewer and take responsibility for submitting the review.
- If it is identified that there has been significant clinical care delivered within NHS Borders, the clinical link within that department will be asked to contribute towards the review.
- A register of all multiagency staff will be documented within the Child Death documentation.
- Learning outcomes should be shared between both NHS Health Boards and relevant Multiagency staff.

Children from NHS Borders who die Overseas

- When a child or young person, who is a resident of NHS Borders dies overseas, it would be expected that the residing NHS Board takes responsibility to conduct a review to the best of their ability.

- The death notification may be delivered from a variety of sources including the Foreign and Commonwealth Office, GP, Family members or Media.
- Conducting a review into the death of a child or young person under these circumstances can be challenging, as these deaths will be registered overseas where the death took place.
- The National Hub will work with colleagues from the Death Certification Review Service, to ensure deaths abroad that are reported to the appropriate NHS board.

Children from NHS Borders who die in a partner NHS Health Board

- A notification should be submitted to the Child Death mailbox (BOR.childrensreviews@borders.scot.nhs.uk).
- A request should be sent to identify a Clinical Link to support the review
- A NHS Borders lead is expected to be identified to lead the review process.
- On completion of the review, the report should be shared in full with the partner Health Board and learning outcomes to be highlighted.

5.7 Consideration of Established Review Processes

There are some examples of exceptional review processes within NHS Borders that already exist and the CDR process does not intend to replace any of these processes. It is to act as a collation point for all outcome reports that relate to the child's death. Some of the processes that exist are below

Significant Adverse Event Reporting

A SAER may be commissioned regarding any child death that is considered unexpected. It will certainly be commissioned if it is a Duty of Candour Event.

In the event that the SAER is commissioned, The CDR Team will work closely with Clinical Governance SAER Team to ensure that there is only one initial contact with the family, and clear explanation that there will be both an SAER and CDR report.

The SAER report will form part of the CDR Report.

5.8 Information Governance Arrangements

All information gained throughout this process whether it is in a Clinical format or created for database purposes which relates to the patient or family will meet the minimum standards of all Data protection local and national policies.

Information relating to NHS Borders Health Board patients held on NHS Borders Systems

- Families will be informed that there will be a Quality Death review of their child/young person and that the review will include the collation of information relating to their child's health and social circumstances.

- Information that is collated may be shared with relevant multiagency staff for educational purposes, however if used for these reasons all aspects of the child's information will be carefully anonymised.
- Information that is collated may also be shared with official multi agency partners identified through the national hub for the purposes of improving health care provision.

Information relating to non NHS Borders Patients held on NHS Borders Systems

- Information that is collated may be routinely shared with Partner NHS health boards' staff members for the purposes of improving health care provision. The expectation would be that the Partner NHS health boards would notify the parents that they are conducting a review and that the review is joint between both health boards therefore information will be shared to complete the review.

5.9 Quality Assurance Process

- The Clinical Lead will draft the final outcome report, in partnership with CDR team members. **A template for the report** can be found in the Appendices.
- Once the report has been drafted, the report should be circulated to other members of the CDR Team to allow for factual accuracy cross- checks
- Once contributors have confirmed the factual accuracy of the report, the final draft should be forwarded to the CDR Team Lead for fresh cross- reference against the agreed **quality standards** which can be found in the appendices.
- The report should contain tracked changes and any old drafts saved and stored with date.
- Once the report has been finally signed off by the Clinical Lead it can be submitted to the national hub and a further version filed in the patient's case notes.

6.0 Reporting and Governance within NHS Borders of the CDR Review Outcome

It is important that there is a robust reporting mechanism around:

- Process set up and management
- Review of cases and learning outcomes.

6.1 Communications Team

The Communications and Engagement team provides the expert capacity to NHS Borders and the wider Health and Social Care Partnership to develop effective corporate messages in order to communicate with staff, the public, media, partner organisations, politicians and other stakeholders.

In circumstances surrounding a child or young person's death there is a high likelihood of media interest, and approaches may be made direct to staff or family members.

For this reason, it is recommended that the communications team is alerted to the death of a child or young person as soon as possible, and particularly if there may be media interest or there is a time sensitive / urgent requirement to issue communications.

Examples of this could be:

- Public Health Concern i.e. Meningococcal/E.coli infection
- Suicide
- Drug related death
- Unexplained death
- Clusters or potential related causes of death

Contact with the Communications Team should be sent by email to communications@borders.scot.nhs.uk

All contact will be dealt with in strict confidence.

6.2References

- National Hubhttps://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/deaths_of_children_reviews.aspx

- Core review Data Sethttps://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/deaths_of_children_reviews.aspx

- NHS Lothian CDR Documentation

- NHS GGC CDR Documentation

7.0

APPENDICIES

(A) DAY 42 LETTER(remove prior to sending)

Child Health
Borders General Hospital
Melrose
TD6 9BS
Our Ref: CHI Number
Date: DD Month 2021
Our Email: BOR.childrensreviews@borders.scot.nhs.uk

Private & Confidential

Mr First Name; Surname Mrs First Name; Surname
Postal Address (if printing, please use plain white paper)

Email Address (all communication should ideally be electronically)

Dear Mr and Mrs

Further to our meeting on [date], I wanted to contact you with an update.

Thank you for meeting with Dr X and myself. I appreciate this will have been a very difficult meeting for you. We discussed
 Bullet Points

I trust this was helpful information for you.

As previously advised, when (child's first name) post mortem is available we will convene a review meeting between public service professionals. I will use any information you have provided me with so far at this meeting, and will raise any questions you have asked. Further to this, I have also enclosed a feedback form with this letter should you have any additional queries you wish us to explore.

I will be in touch when we are planning to hold the review meeting. I must advise that due to the timescales involved, this may take up to 12 months. We will provide you with an update as to any progress.

We will write a report to summarise the review findings and address any questions and comments you have made to the best of our ability. I will invite you to a meeting with me to discuss the findings of the review, or alternatively you can discuss this with your GP who will also have a copy of the report if you wish.

If we do not hear back from you, we will keep a copy of the report in (name) medical notes. You can receive a copy whenever you wish by contacting us on the details above.

A copy of the report will also be submitted to the National Hub Child Death Review Team who collates information on all children who have died in Scotland.

I have enclosed information regarding Child Bereavement UK and would be happy to assist in referral to them, should you wish me to do so.

As noted during our meeting, should you wish a follow up meeting in the interim, or if you have any queries please do not hesitate to contact me on the email address above.

Yours sincerely

Clinical Lead

(B) FOLLOW UP LETTER (remove prior to sending)

Child Health
Borders General Hospital
Melrose
TD6 9BS
Our Ref: CHI Number
Date: DD Month 2021
Our Email: BOR.childrensreviews@borders.scot.nhs.uk

Private & Confidential

Mr First Name; Surname Mrs First Name; Surname
Postal Address (if printing, please use plain white paper)

Email Address (all communication should ideally be electronically)

Mr and Mrs

Further to our meeting on [date], I wanted to contact you with an update.

Thank you for meeting with Dr X and myself. I appreciate this will have been a very difficult meeting for you. We discussed
 Bullet Points

I trust this was helpful information for you.

As previously advised, when (child's first name) post mortem is available we will convene a review meeting between public service professionals. I will use any information you have provided me with so far at this meeting, and will raise any questions you have asked. Further to this, I have also enclosed a feedback form with this letter should you have any additional queries you wish us to explore.

I will be in touch when we are planning to hold the review meeting. I must advise that due to the timescales involved, this may take up to 12 months. We will provide you with an update as to any progress.

We will write a report to summarise the review findings and address any questions and comments you have made to the best of our ability. I will invite you to a meeting with me to discuss the findings of the review, or alternatively you can discuss this with your GP who will also have a copy of the report if you wish.

If we do not hear back from you, we will keep a copy of the report in (name) medical notes. You can receive a copy whenever you wish by contacting us on the details above.

A copy of the report will also be submitted to the National Hub Child Death Review Team who collates information on all children who have died in Scotland.

I have enclosed information regarding Child Bereavement UK and would be happy to assist in referral to them, should you wish me to do so.
As noted during our meeting, should you wish a follow up meeting in the interim, or if you have any queries please do not hesitate to contact me on the email address above.

Yours sincerely

Clinical Lead

(C) Day 84 Unable to Reach (remove prior to sending)

Child Health
Borders General Hospital
Melrose
TD6 9BS
Our Ref: CHI Number
Date: DD Month 2021
Our Email: BOR.childrensreviews@borders.scot.nhs.uk

Private & Confidential

Mr First Name; Surname Mrs First Name; Surname
Postal Address (if printing, please use plain white paper)

Email Address (all communication should ideally be electronically)

Dear Mr and Mrs,

I am following up on my letter of (date). I was very sorry to learn of the death of (name). I realise this letter comes at a very difficult time for you and your family.

A team of multiagency professionals is working together to look at all of the information to try and give your family as much information as possible about why (first name) died. We will also be meeting together with other Health and Social care service professionals to share our information. This is called a Review meeting and will take place in the coming months.

Your thoughts and questions are important and it would be extremely helpful if you felt able to share your experience or any questions you have before we carry out the review. You can do this by contacting me on the details above, I will be your key worker for the review.

I enclose a feedback form with this letter to help you think about questions you may have. These may be about the emergency department, police liaison and family support service, bereavement support or indeed any other questions you may have.

You can either post the feedback form back to me, or return via email to patient.safety@borders.scot.nhs.uk.

It may take over a year for the review meeting to take place. This is to ensure that all the information is available and that the right professionals can attend. You will not be asked to attend the meeting in person.

We will write a report to summarise the review findings and try to address any questions and comments you have made to the best of our ability. I will then be in touch with you to offer you a

meeting to discuss the findings of the review, or alternatively we can telephone, email or write to you.

Within this letter I have provided information from Child Bereavement UK. If you have any questions about this letter, please do not hesitate to contact me on the email address above.

Yours sincerely,

{Name}
Clinical Lead

(D) ATTACHMENT TO DAY 84 LETTER (remove before sending)

Feedback Form for Parents and Carers

This form is designed to help you think about any questions or comments you may have following the death of your child. You do not have to use this form or limit yourself to the spaces in these boxes. The form is just a way of triggering your thoughts.

Any feedback you give us will help the hospital to ensure we address your questions as best we can.

You can post the feedback form back to us at Child Death Review Team, Child Health, Borders General Hospital, Melrose TD6 9BS or email BOR.childrensreviews@borders.scot.nhs.uk.

Care prior to your child being taken to the emergency department/Ward area

Please use this space to write down any questions or comments you may have regarding the care of your child prior to them being taken to hospital.

Care in the Emergency Department/ward area

Please use this space to write down any questions or comments you may have regarding the care of your child whilst in the Emergency Department.

The care of you and your family afterwards.

Please use this space to write down any questions or comments you may have regarding the care you and your family received after you left the hospital.

Any further comments

If you would like to comment on the support you received around the time your child died or any other comments please do so here.

(E) REVIEW MEETING LETTER (remove before sending)

Child Health
Borders General Hospital
Melrose
TD6 9BS
Our Ref: CHI Number
Date: DD Month 2021

Our Email: BOR.childrensreviews@borders.scot.nhs.uk

Private & Confidential

Mr First Name; Surname Mrs First Name; Surname
Postal Address (if printing, please use plain white paper)

Email Address (all communication should ideally be electronically)

Mr and Mrs,

In my letter of (Date), I committed to update you with regards to the review meeting that will take place in respect of your son / daughter (child's name) death.

I can confirm that the meeting is scheduled to take place on (date). I will be the Chair of that meeting.

DELETE AS APPLICABLE

a) You have asked me to raise questions on your behalf and I have attached a copy of those questions to this letter as a reminder. If you have anything further you would wish us to explore, please do forward that on to me no later than (Date). You can do so by sending it to the named person below.

OR

b) I appreciate thinking of any questions you wish raised on you and your family's behalf will be very difficult. However, I do want our team to consider any outstanding queries you may have and as such would like to extend my invitation to you to contact me any time up until (date) with those questions. You can do so by sending it to the named person below.

Once the meeting has taken place, I will invite you to meet with me, should you wish to do so.

I appreciate this letter will have opened up the grief you inevitably feel regarding the loss of your (son/daughter).
If I may be of any further support or assistance, please do contact (Project Officer's name) by emailing (Project Officer's email details).

Yours sincerely

Dr
Clinical Lead

(F)

Parent/Carer Support Leaflet

This information is for parents and carers of a baby, child or young person aged under 18 who has died. This leaflet will inform you of the review that will take place regarding your child.

Introduction

The death of a child is always a tragedy. Talking and thinking about a child's death is a sensitive, very difficult and painful subject. We understand that this will be particularly upsetting for parents, families and carers. This leaflet explains some of the things that have to happen after your child has died. It also includes a list of bereavement agencies which you may find helpful.

A team of relevant multi-agency professionals which may include health, emergency services, social work and education will be working together to ascertain why your child died.

We will look at your child's history, their health records; we will review feedback from people who may have tried to assist your child and we will consider any relevant underlying clinical conditions your child may have had. This review is mandatory in Scotland and is called a "Child Death Review".

It is important that we conduct reviews so we can better support families and prevent future deaths if we are able to.

Keeping you informed

A key worker will be able to provide support and answer any questions you may have, your key worker may be someone who has spent time with you and your family, or this may be a health professional who you have met recently.

Initial response

If your child has a long-term illness or life-limiting condition it may be that you have already discussed a care plan with a member of the team in the event your child becomes more unwell. The hospital and local hospice will work with you to support you at this difficult time.

An unexpected death is usually sudden. The death may be due to an accident or have no obvious cause. In these cases, it is a legal requirement to report the death to the police and the procurator fiscal. They will ask a number of questions which may be very upsetting but is necessary and the information you provide is very valuable.

A post mortem will take place and a provisional death certificate will be available. At this point the funeral can be arranged. The exact cause of death may be unknown until the full post mortem result is available.

If the death was unexpected you will receive a letter at 6 weeks from our team offering you the opportunity to meet with a member of the review team, your key worker and the paediatric consultant who was involved in the care of your child. We would like to answer any questions you have and offer our ongoing support.

If your child had a chronic condition a member of the team who you know well will get in touch with you.

A member of the family support team from the procurator fiscal will contact you. When the final post mortem is available you will be invited to a meeting with the pathologist to discuss the findings. It may be helpful to write down any questions you might have for them.

When all the investigations are complete a meeting is arranged with all the multi-agency professionals involved in your child's care. This can take a variable amount of time depending on the circumstances, even up to and beyond one year waiting on the final pathology results. We understand that this is a very long wait for families which can be distressing.
We would welcome any questions you may have before the meeting and your key worker will raise these on your behalf. Your key worker will provide feedback from the meeting if you would like this and would find it helpful.

Every case is reviewed to consider whether there are any recommendations or learning outcomes to try and prevent future deaths or improve services for children and their families. These recommendations are shared both local and nationally with the Scottish Government Hub for Reviewing and Learning from the Deaths of Children and Young People

Useful contacts

Spiritual Care Chaplain NHS Borders
Telephone: 01896 826564

Community Listening Service NHS Borders
Email: sandra.henwood@borders.scot.nhs.uk
Telephone: 01896 826564

Borders Child Bereavement Network
Telephone: 01896 826081/ 826835

Child Bereavement UK
Telephone: 0800 02 888 40
Email: helpline@childbereavementuk.org

Scottish Cot Death Trust
Telephone: 0141 3573946
Email: contact@scottishcotdeathtrust.org

Held in our Hearts
Bereavement support for baby loss up until age of 5
Telephone: 0131 622 6263
Email: info@heldinourhearts.org.uk

Your local contact:

Dr Clare Ketteridge - Clinical Lead for Child Death Review Team
Shona Finch - Clinical Nurse Manager in Woman and Child Services
Ailie Ramage - Staff Nurse/Project Manager for Child Death Review Team

(G) Post Review / Report Letter (Remove before sending)

Child Health
Borders General Hospital
Melrose
TD6 9BS
Our Ref: CHI Number
Date: DD Month 2021
Our Email: BOR.childrensreviews@borders.scot.nhs.uk

Private & Confidential

Mr First Name; Surname Mrs First Name; Surname
Postal Address (if printing, please use plain white paper)

Email Address (all communication should ideally be electronically)

In my letter of (Date), I offered to invite you to meet with me after the review meeting that took place regarding your son / daughter (child's name) death, [delete as applicable] in order to answer the questions you asked me to raise on your behalf.

The review has now taken place.

If you would like to meet with me, either in person on via an online platform (such as Microsoft Teams) or by telephone please contact (Project Officer and telephone number) who will arrange a time and place that is convenient for you.

I do understand this will be a very upsetting and difficult meeting for you, and therefore, I want you to know there is no immediacy to make up your mind as to whether you wish to attend or not.

Yours sincerely

Dr
Clinical Lead

Information Gathering Document

CHILD DEATH REVIEW TEAM

OFFICIAL – SENSITIVE – PERSONAL

REQUEST FOR INFORMATION TO CONDUCT A QUALITY DEATH REVIEW

- You have been invited to participate in a Child Death Review and we would like to ask you to complete this request for information.
- Could you please provide a timeline of services provided to the Child/Young Person that may be helpful to the Child Death Review Team in collating information leading up to the child/young person's Death
- This is required to be completed within 10 calendar days and sent electronically, to BOR.childrensreviews@borders.scot.nhs.uk.
- Please provide some very initial reflection regarding good practice and any learning points identified.
- Please be reassured that this process should be seen as an opportunity for learning and a supportive team environment. Peer support will be available throughout.

W Number identifier:	
Date request sent:	

Child's Name and Identifier number:	
Date of birth:	
Date of death:	
Age at death:	
Gender:	

Please provide the following information (if known)

Names of child's parents/carers and dates of birth:	
Names of siblings and dates of birth:	

Child's home address:	
Education establishment details:	
Summary of involvement with the child/Young person and family:	
Date of Last Contact:	
Reason for last Contact:	
Background history:	

Key practice issues: Please provide information on: • any good practice identified • any areas identified for practice improvement

Parallel processes	
Are you aware of any current or planned reviews being undertaken for this case? If yes, please give details.	
Are you aware of any criminal proceedings associated with this case? If yes, please give details.	

Report completed by	
Name	
Title	
Agency	
Email address	
Date	

Child Death Review Team
Ward 15
Borders General Hospital
Melrose
TD6 9BS

Email: BOR.childrensreviews@borders.scot.nhs.uk

Report Author:
Report Administrator:
Contact Email:

Name:	
CHI:	
Date of Birth:	
Date of Death:	
Date of Review Meeting:	
Date of Report:	

Meeting Attendees:

Name	Designation	Organisation

Meeting Apologies:

Name	Designation	Organisation

The Purpose of the Review

There is now a requirement that every child and young person who dies between 0-18 and those 18 to 26 year olds who are in / have been in receipt of aftercare or ongoing care from their local authority have a multidisciplinary child death review meeting.

The purpose of the review is to explore the circumstances of their death, the relevant medical and social background and post mortem findings in an attempt to identify relevant factors that may be important in explaining what happened.

The following will be considered:

1. Final cause of death and of any relevant associated factors.
2. The ongoing support needs of the family and/or siblings
3. Relevant plans for supporting any potential future pregnancies.
4. Any points of communication for the family.
5. Any factors which are potential leaning opportunities for NHS Scotland and in particular NHS Borders in the context of this death event.

Summary of event:

Post mortem has given the cause of death as:

Review Methodology

Review tool	**Methodology**
Professional Debrief	Discussion involving all members of the team at the resuscitation on
Timeline	A timeline of the patient's care was constructed using the patient's healthcare records
Case Presentation and discussion	Presentation and group discussion of the patient's care which took place on
Acute hospital	Contacts with Borders General Hospital (BGH) including visits to

records	Emergency Department (ED) were reviewed.
Information Gathering Documents	Provided by:
Post-mortem	Review of post-mortem notes and findings.
Child Death Review	via Teams Present:

Case timeline:

Past Medical History:

Perinatal history:

Family history:

	Name	Age
Parent 1		
Parent 2		
Sibling		
Sibling		
Sibling		

Social History:

Post Mortem results:

Staff and Patient/Family Involvement:

Patient/Family Involvement:

Involvement of Staff:

- **Good Practice Points identified:**

- **Areas for discussion:**

Post event family Support/Pastoral Care:

Summary of Discussion at Review:

Conclusions:

Recommendations / Learning Points:

Governance

This report has been confirmed as correct by all those listed as contributors. I Dr …… therefore confirm this report to be factually correct and accurate to the best of my knowledge.

This report was quality assured by

A Copy of this report will be distributed as follows:

National Hub for Scotland Review Hub
NHS Borders Governance Group
NHS Borders Child Death review Group
Medical notes
DATIX

Signature of Author

Name of author

Date of final report.

(J) Terms of Reference – Governance of Child Death Reviews

Accountable to

Lynn McCallum – Medical Director/Trust Management

Purpose

Implementation of National Hub Death reviews for all live born babies, children and young people aged 0-18 and looked after young people aged 18-26 years who live within NHS Borders Locality.

In addition, this group will report upon reviews of all babies, children and young people who have received relevant health care from NHS Borders and subsequently died, regardless of their demographical location.

Governance

The governance of this group sits with Lynne McCallum – Medical Director. Reports prepared will be shared as required with the Board Governance Group.

Membership

Shona Finch	CDR Management Lead
Dr Clare Ketteridge	CDR Clinical Lead
Ailie Ramage	CDR Project Manager
Joanne Forrest	Clinical Risk Coordinator
Laura Jones	Head of Quality and Clinical Governance

Responsibilities

- To ensure an effective system is devised that will record each NHS Borders Resident child who has died, that supports the recording to ensure that child receives the full care and support of relevant services including memory making, formal review and family bereavement support.
- To identify any gaps in the service delivery of any children who have died with a view to ensuring all relevant services are available to children and their families
- To share and debate good practice specifically relating to caring for children who are dying, who have died and the after care for their family.
- To respond to current policy and guidance and disseminate as appropriate

- To ensure all accountable aspects to national hub are achieved
- To review outcome reports and share learning with wider community.
- Agree recommended outcomes to the management team.
- Refer issues to the directorate senior management for further debate /implementation
- Information sharing with colleagues – engaging with staff to find out if there are any issues which could be addressed by the group
- Provide information for families and colleagues updating them on the work of the group
- Communication across other sectors and directorates in order to progress the child death review process.

Frequently Asked Questions

Why have I been invited to the Review?

A child or young person known to you or your service has recently died. There is to be a review of the Child or Young person's death and you have been invited to join this to contribute to the discussions.

What is the purpose of the Child Death Review?

The Scottish Government has developed The National Hub for Review and Learning from the Deaths of Children and Young People which is supported by Healthcare Improvement Scotland and the Care Inspectorate. The aim of the programme is to ensure that from the 1st October 2021, the death of every child or young person is reviewed locally by a team of professionals to explore the circumstances surrounding their death in more detail and any other aspect of the care provided to them and their family.

The purpose of the Child Death Review (CDR) is to identify good practice and local learning from the death as well as to highlight any factors which could influence national policy.

What can I do to prepare myself for the review?

Take some time to read through your records of your contact with the child / young person. It can sometimes be weeks or months between when the child or young person has died and the review so you may need to refresh your memory. If you have been involved in the care of the child or young person for many years, focus mainly on the more recent months leading up to their death.

Do I need to prepare a report or chronology before I come to the review?

You will be invited to tell the review group about your role with the child /young person who died and participate in the discussion. Some people find that it helps to have some notes to refer to during the review. An 'Information Gathering' Document will be sent out to you that we would ask be completed and returned to the CDR Team within 10 days of receiving the document.

Are the reviews face to face or on MS Teams?

At the moment, and for the foreseeable future, all the reviews are being held virtually using MS Teams. You will be sent a link so you can join the review.

What happens if I can't come to the review?

If you are unable to attend the Review, please do let us know as soon as possible. We would ask that where possible you identify a peer who would be able to come in your place to provide a summary for the Child or Young Person's care in your area. Where this isn't possible please send a typed summary to the CDR team in advance of the review. The chair will read this out and then any questions the panel may have following the review we would send on to you.

If I have questions or concerns before the review, who should I contact?

Please email the CDR mailbox on BOR.childrensreviews@borders.scot.nhs.uk. Your email will be directed to someone in the team who can help. Please include a contact number in your email so they can get back to you in person.

How long should I book out in my diary for the review?

Reviews vary in length but they can take 2 hours.

Can my line manager or Clinical Supervisor join me at the meeting?

Clinicians and professionals are welcome to invite their line manager or clinical supervisor.

Who else will be at the review?

This is a multi-agency review so several different agencies and organisations may be represented.

The family of the Child or Young person who has died will not be present. For deaths from October 2021, the family will be informed of the review and will be invited to submit questions.

Key clinical and Local Authority staff that have provided assessment, care and treatment to the child/ young person will be present along with representatives from the Police and Scottish Ambulance Service who attended after the child's death.

What happens at the Review meeting?

The Chair will introduce the purpose of the meeting and invite everyone to introduce themselves. S/he will share some basic information about the child or young person and then ask others in the meeting to discuss their understanding of the child's health and circumstances leading to their death. We will try to identify together examples of good practice as well as honestly and openly look for learning which may improve future practice. We will discuss the support and communication we have had with the child or young person's family following their death. The family will have been asked if they have any questions, they wish the review group to consider. We will discuss their questions together; agree how we will share our responses with them and offer support going forward.

If I find the review upsetting what should I do?

Send a private message to the Chair. If you feel you can't stay in the meeting, please feel able to leave and the Chair will get in contact after the meeting to let you know about the rest of the review and to check in with how you are.

If I feel anxious or upset after the review who can I speak to?

Sometimes remembering the difficult experiences and circumstances leading up to the death of the Child or Young person can bring back upsetting and difficult memories. Talking about death and loss can sometimes touch us very personally, reminding us of our own losses and grief.

The Community Listening Service NHS BORDERS may help if you would like to talk things over with someone else in complete confidence. You can contact them on 01896 826564

If you have questions or concerns about the review process itself, please contact the Chair directly by email.

What happens to the information discussed at the review?

The dataset is sent to Health Improvement Scotland who are the host organisation for the national programme. They are gathering information from all the Health boards in Scotland with the aim of reducing preventable deaths in children and young people.

The learning from the reviews is shared locally and nationally.

April 2022

Ailie Ramage – Project Manager
NHS Borders Child Death Review Team