Royal Hospital for Children, Glasgow

Document Title: **Child Death Review Reporting Procedure**
Document Type: **Child Death Reviews**
Document No/Version: **RHC-CDR-FINAL V2.0**

Author: 1) **Coral McGowan Programme Lead;** 2) **Amita Sharma CDR Clinical Lead;** 3) **Lynn MacLeod SUDI Clinical Lead**	Signature	Date:
Authorised by:	Signature	Date:
Issue Date:	**1 December 2023**	
Date Effective From:	**Immediate**	
Review:	**Every two years**	

Detail of Amendments Made to Previous Version

Paragraph/Line	Amendment	Signature	Date

Contact Details:

Child Death Review Team Programme Lead: Coral McGowan
Coral.mcgowan@ggc.scot.nhs.uk

Child Death Review Team Clinical Lead: Dr Amita Sharma
Amita.sharma@ggc.scot.nhs.uk

SUDI Clinical Lead: Dr Lynn Macleod
Lynn.Macleod2@ggc.scot.nhs.uk

16-26 Clinical Lead: Dr George Oommen
George.Oommen@ggc.scot.nhs.uk

Neonatal Clinical Lead: Dr Laura Mcglone
Laura.Mcglone@ggc.scot.nhs.uk

Child Death Review Team: ggc.cdr@ggc.scot.nhs.uk
Telephone: 07929 659967

CONTENTS PAGE

1. 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 Healthcare Improvement Scotland and the Care Inspectorate) require us to standardise the way in which we review, record and report all children within NHSGGC aged 0 – 18 (or up to aged 26 if in receipt of ongoing care or aftercare in local authority care) who have died. This information will feed into the national child mortality database owned by the National Hub.

1.2 The outcome of all information is expected to be the identification of modifiable or preventable factors in the deaths of children. This work will be undertaken in collaboration between NHS Boards; Local authorities (including HSCP), Healthcare Improvement Scotland and the Care Inspectorate.

1.3 A team has been established within hospital paediatrics consisting of clinical and administration representatives to establish and maintain the service.

1.4 This SOP suggests a process for managing reviews.

- Neonatal (for children under 28 days and for those babies whose whole of life has been in a neonatal intensive care unit)
- SUDI (children aged 29 days – 2 years)
- Child Death Review (children aged 2 years – 18 years)
- Care Experienced Young People – 18+ who are still in receipt of care or aftercare.

1.5 Clinical Leads have been identified for the above process, however, to ensure a sustainable, manageable process the work relating to SUDI and CDR will involve close cross cover.

2. RELATED DOCUMENTATION

2.1 Datix feedback form
2.2 NRS report
2.3 GGC Hub database
2.4 Parent letters
2.5 Patient medical notes
2.6 Any additional patient related reviews eg SAER
2.7 Feedback for multiagency reports
2.8 HIS core data set report
2.9 Learning outcomes
2.10 ED Bereavement Leaflet
2.11 CDR Parent Support Information Leaflet

3. AUTHORISED PERSONNEL AND STAFF COMPETENCIES

a. AUTHORISED PERSONNEL

3.1 Clinical Lead (for CDR)
3.2 Clinical Lead (for SUDI) – cross-cover post with above
3.3 Clinical Lead (for Neonatal Review)
3.4 Clinical Lead (for 16-26 year olds)
3.5 Programme Lead
3.6 Administration
3.7 Other interested parties for example;-

Speciality Clinicians – identified clinical links
Health and Social Care Partnership
Public Health
Clinical Governance
Palliative Care & Hospice Support
Pathology
Child Protection
Child and Adolescent Mental Health Services
Primary Care Health Service
Procurator Fiscal
Police Scotland
Scottish Ambulance Service
Education

(a comprehensive contact list is attached at Appendix N)

b. STAFF COMPETENCIES

Clinical Link

- Access to mentorship
- Root Cause Analysis Training
- Investigative Report Writing Training
- Access to Wellbeing Support

Clinical Lead

- Root Cause Analysis Training
- Investigative Report Writing Training
- Access to Wellbeing Support

4. EQUIPMENT AND/OR MATERIALS

4.1 Internal CDR database for recording all episodes of child death

4.2 Feedback forms for National Hub – Core Review Data Set
https://hisportal.scot.nhs.uk/

4.3 DATIX for reporting Child Deaths

4.4 Meeting facilities (MS Teams or Office Space)

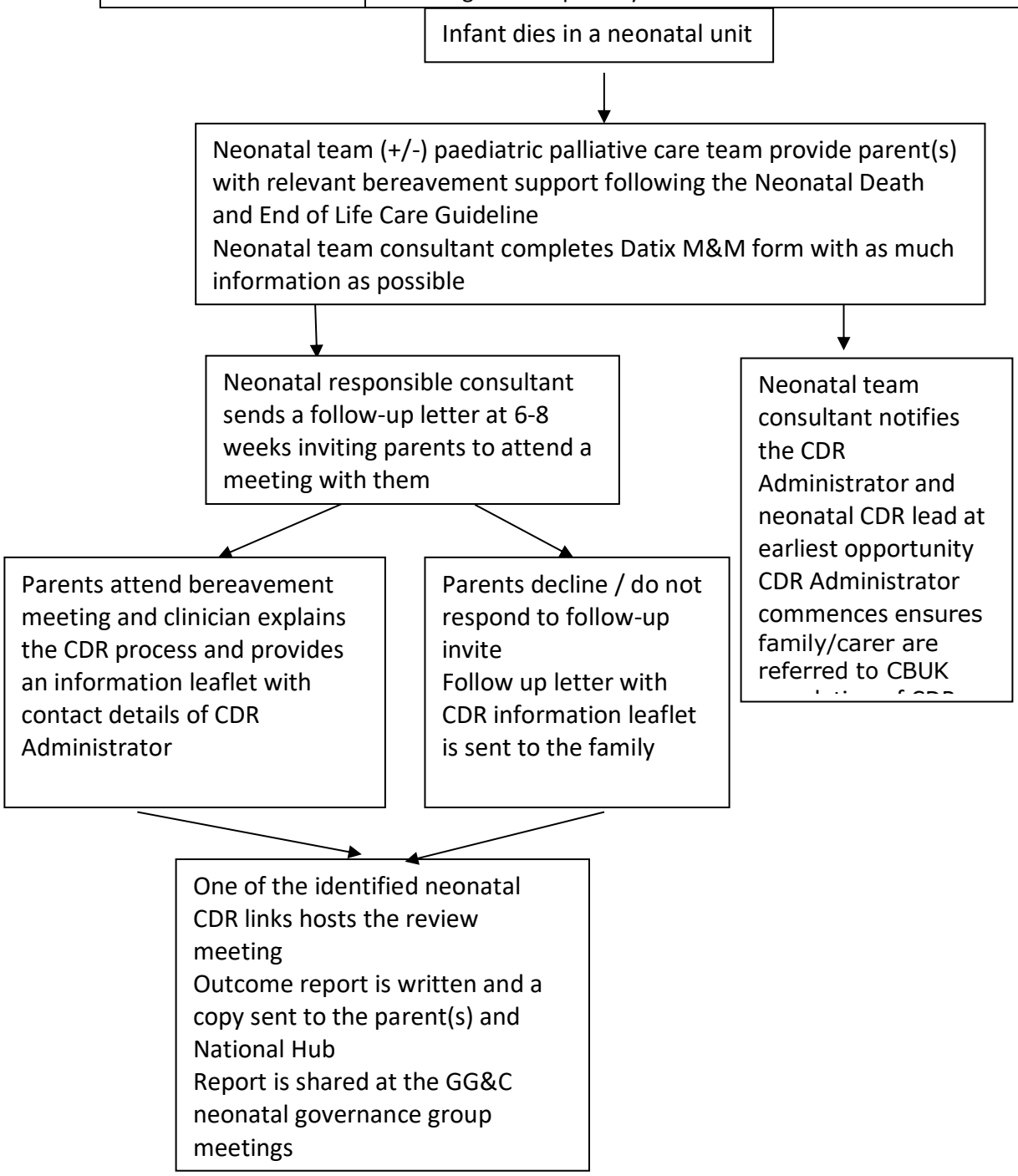
5. PROCEDURE

5.1 Pathway Management Flow Chart

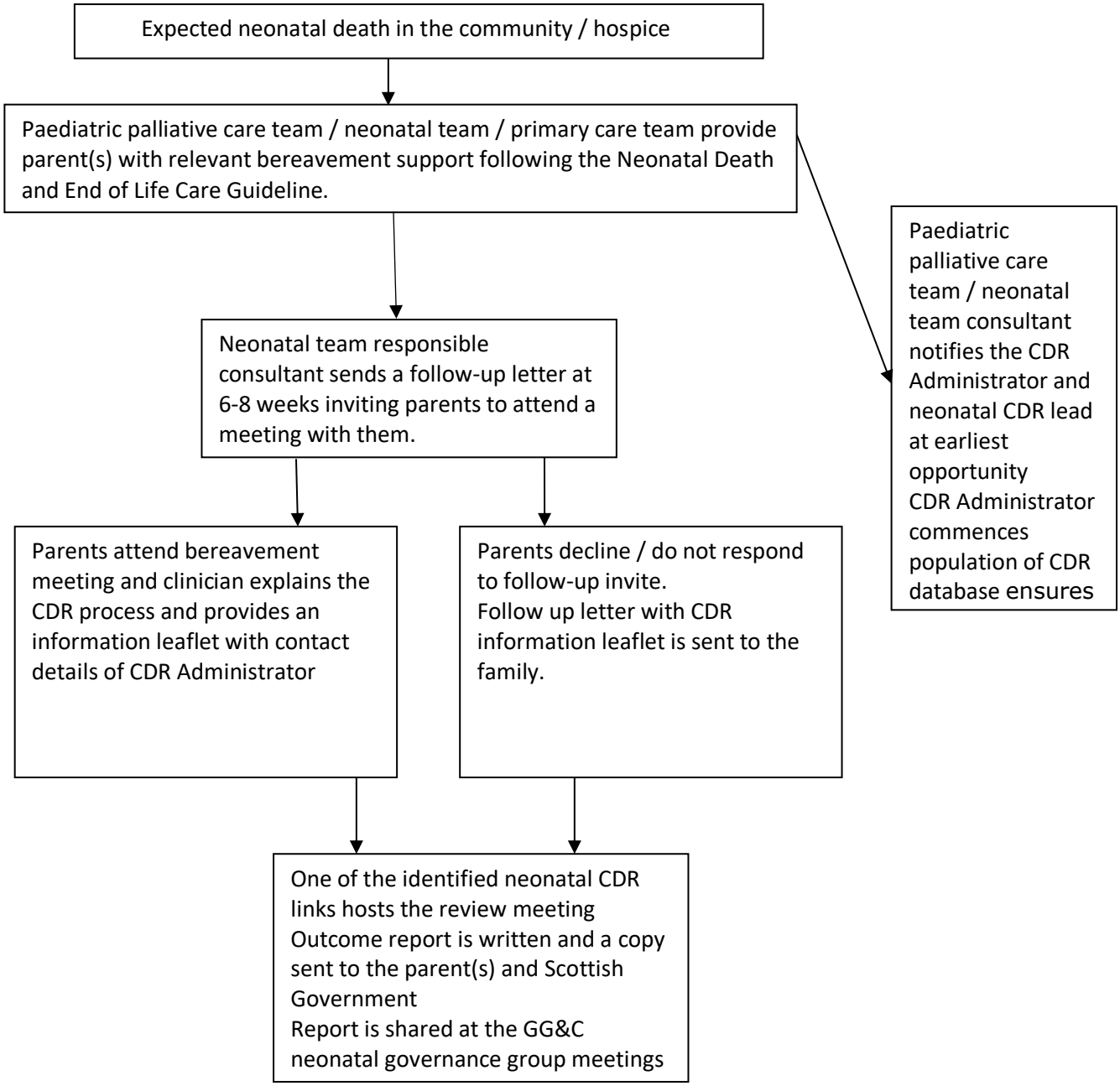
The provided pathways are intended to act as a guide for services. Each newly presented review will be individually considered and allocated to a Clinical Link who may choose to modify the pathway they follow in order to best suit the specific circumstances of the case.

	Pathway Entry to CDR Process	**Age of Child**
1	Death of an infant in a Neonatal Unit (Expected or unexpected)	0-28 days
2	Neonatal Death in the Community - reportable on PMRT (expected)	0-28 days
3	Neonatal Death in the Community - reportable on PMRT (unexpected)	0-28 days
4	Sudden Unexpected Death of an Infant	29 days -1 year
5	Child Death in the Community - Expected	29 days – 18years
6	Child Death in Hospital (excl within Neonatal Unit) - Expected	0 - 18 years
7	Child Death in the Community (except suicide) - Unexpected	2- 18 years
8	Child Death in Hospital - Unexpected	0 - 18 years
9	Death of a Child or Young Person by Suicide and known to CAHMS	0 - 18 years
10	Death of a Child by Suicide and not known to CAHMS	0 - 16 years
11	Death of a Young Person by Suicide and not known to CAHMS	16-18 years
12	Child Death of an Accommodated Child – Expected (links to 5)	0 - 16 years
13	Child Death of an Accommodated Child – Unexpected (links to 7,9,10, 19)	0 - 16 years
14	Death of a Young Person – Expected	16-18 years
15	Death of a Young Person – Unexpected	16-18 years
16	Death of a Care Experienced Young Person - Expected	18-26 years
17	Death of a Care Experienced Young Person - Unexpected	18-26 years
18	Death of an NHSGGC child in a non NHSGGC hospital – Expected	0-16
19	Death of an NHSGGC child outwith NHSGGC – Unexpected (links to 7, 9, 10, 13)	0-16
20	Death of a Young Person in a non NHSGGC hospital - Expected	16-18
21	Death of a Young Person outwith NHSGGC - Unexpected	16-18
22	Death of a Care Experienced Young Person in a non NHSGGC hospital - Expected	18-26
23	Death of Care Experienced Young Person outwith NHSGGC - Unexpected	18-26

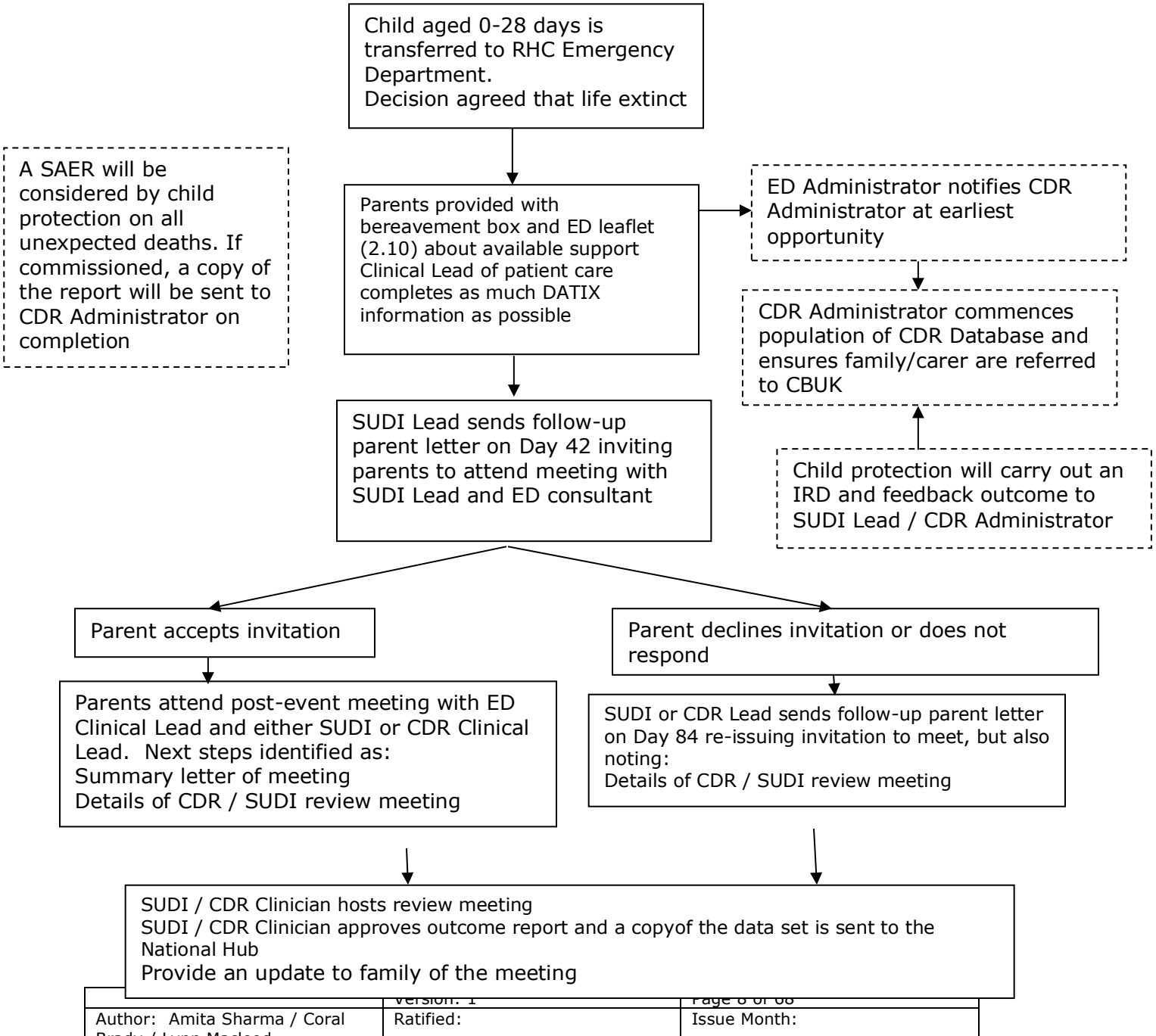
1	Death of an infant in a Neonatal Unit (Expected or unexpected)	0 years
Responsible Service(s):	Neonatal Lead	
	Obstetrics Link	
	Child Protection Link	
	Others eg clinical specialty	



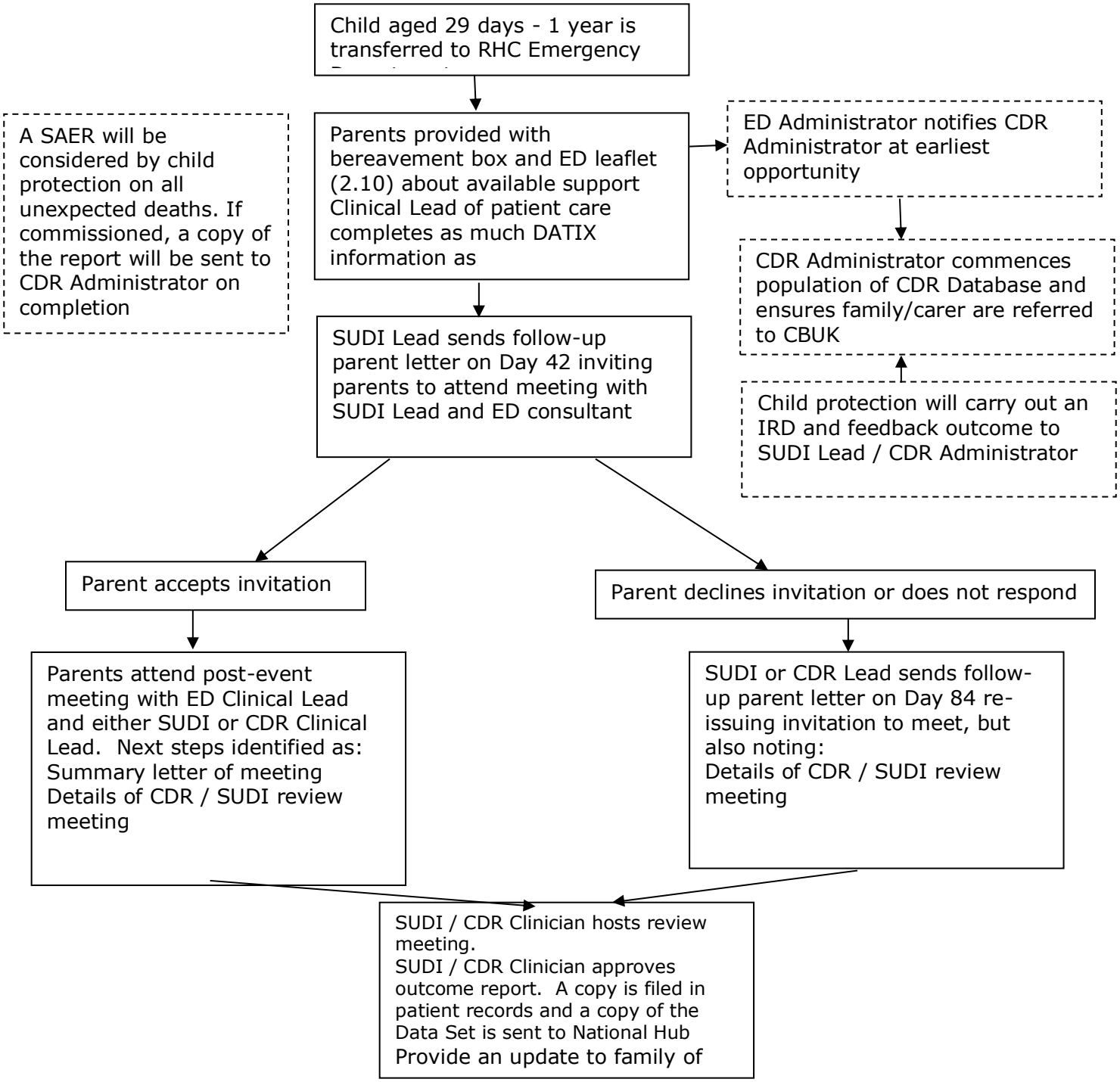
2	**Neonatal Death in the Community – 0-28 days expected**	0-28 days
Responsible Service(s):	Neonatal Lead	
	Clinical Specialty	
	Obstetric Link	
	Palliative Care Team (if applicable)	
	Child Protection Link	



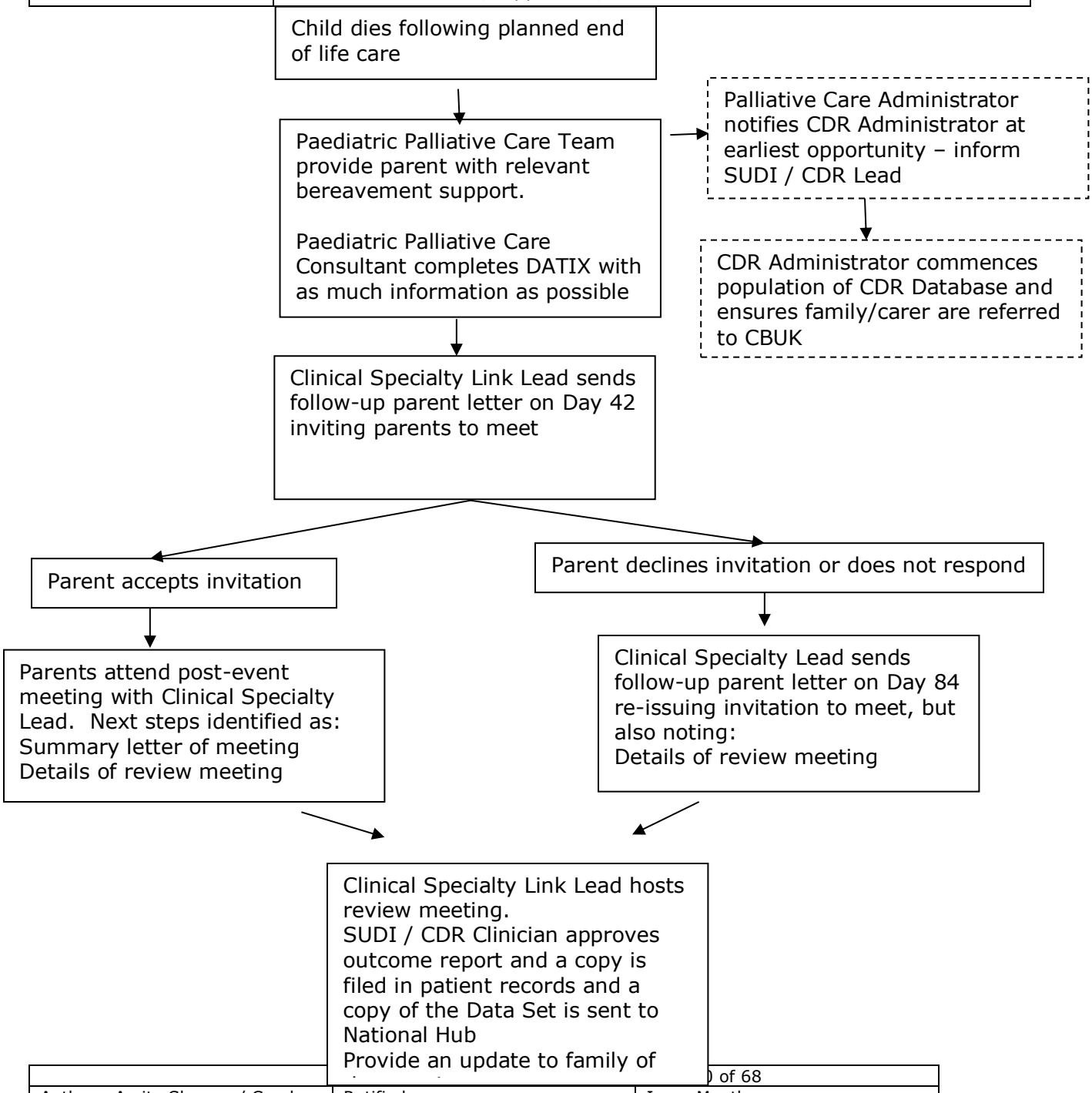
3	**Neonatal Death in the Community – 0-28 days unexpected**	0-28 days
Responsible Service(s):	SUDI Lead	
	Neonatal Lead	
	Child Protection Link	
	Obstetric Link	
	Others eg clinical specialty	



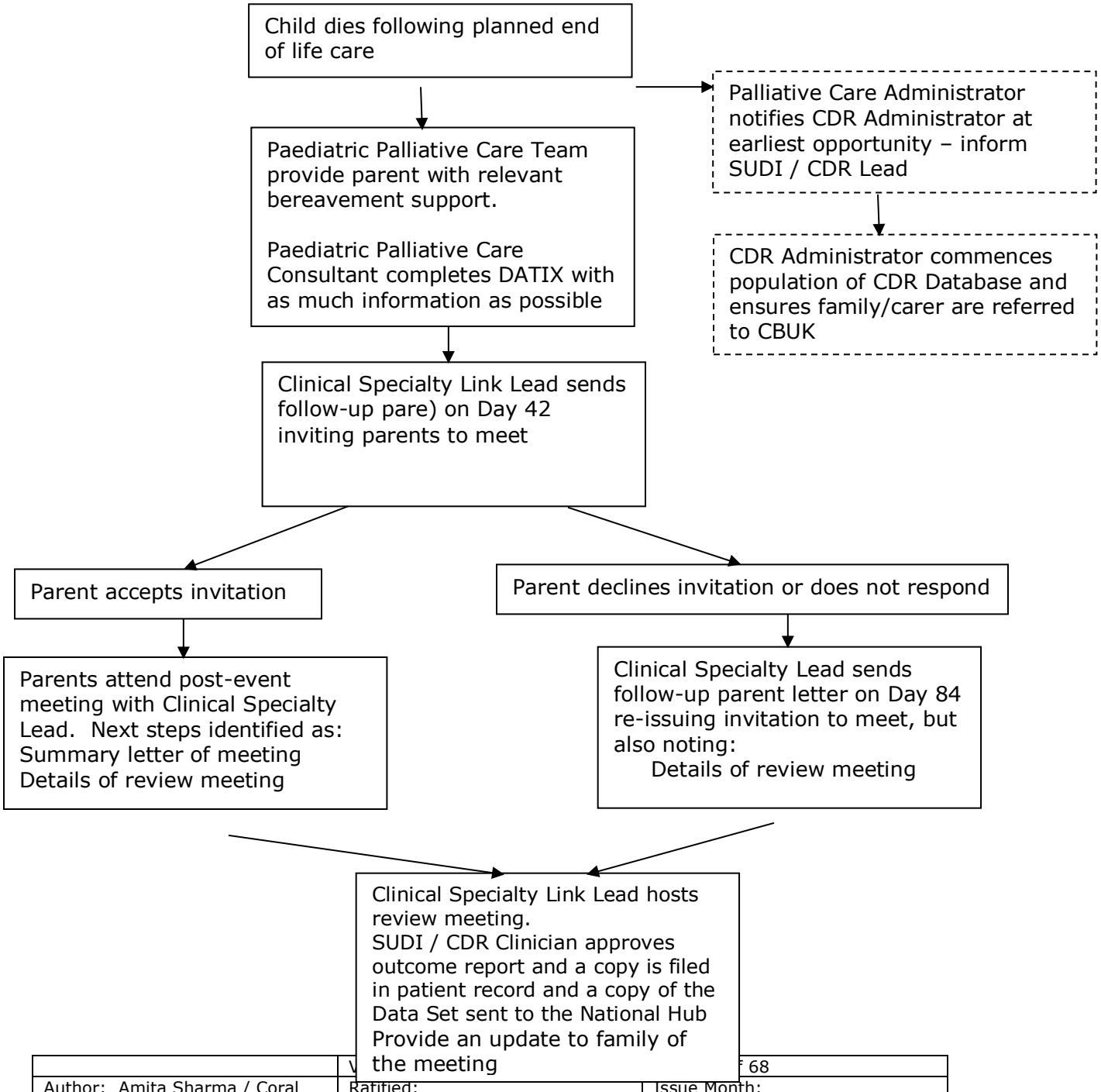
4	Sudden Unexpected Death of an Infant	29 days -1 yr
Responsible Service(s):	SUDI Lead	
	Child Protection Link	
	Others eg clinical specialty	



5	Child Death in Community - Expected	29 days – 16yrs
Responsible Service(s):	Clinical Specialty	
	CDR Lead	
	SUDI Lead	
	Palliative Care Team (if applicable)	
	Child Protection Link (if applicable)	



6	Child Death in Hospital (excluding within neonatal unit) Expected	0 - 16yrs
Responsible Service(s):	Clinical Specialty	
	CDR Lead	
	SUDI Lead	
	Palliative Care Team (if applicable)	
	Child Protection Link (if applicable)	



7	Child Death in the Community Unexpected (except suicide)	1yr – 16yrs
Responsible Service(s):	CDR Lead	
	Child Protection Link	
	Others eg clinical specialty	

Child aged 1-16yrs is transferred to RHC Emergency Department. Decision agreed that life extinct

A SAER will be considered by child protection on all unexpected deaths. If commissioned, a copy of the report will be sent to CDR Administrator on completion

Parents provided with bereavement box about available support
Clinical Lead of patient care completes as much DATIX information as possible

ED Administrator notifies CDR Administrator at earliest opportunity

CDR Administrator commences population of CDR Database and ensures family/carer are referred to CBUK

Child protection will carry out an IRD and feedback outcome to SUDI Lead / CDR Administrator

CDR Lead sends follow-up parent letter and support leaflet (2.11) on Day 42 inviting parents to attend meeting with CDR Lead and ED consultant

Parent accepts invitation

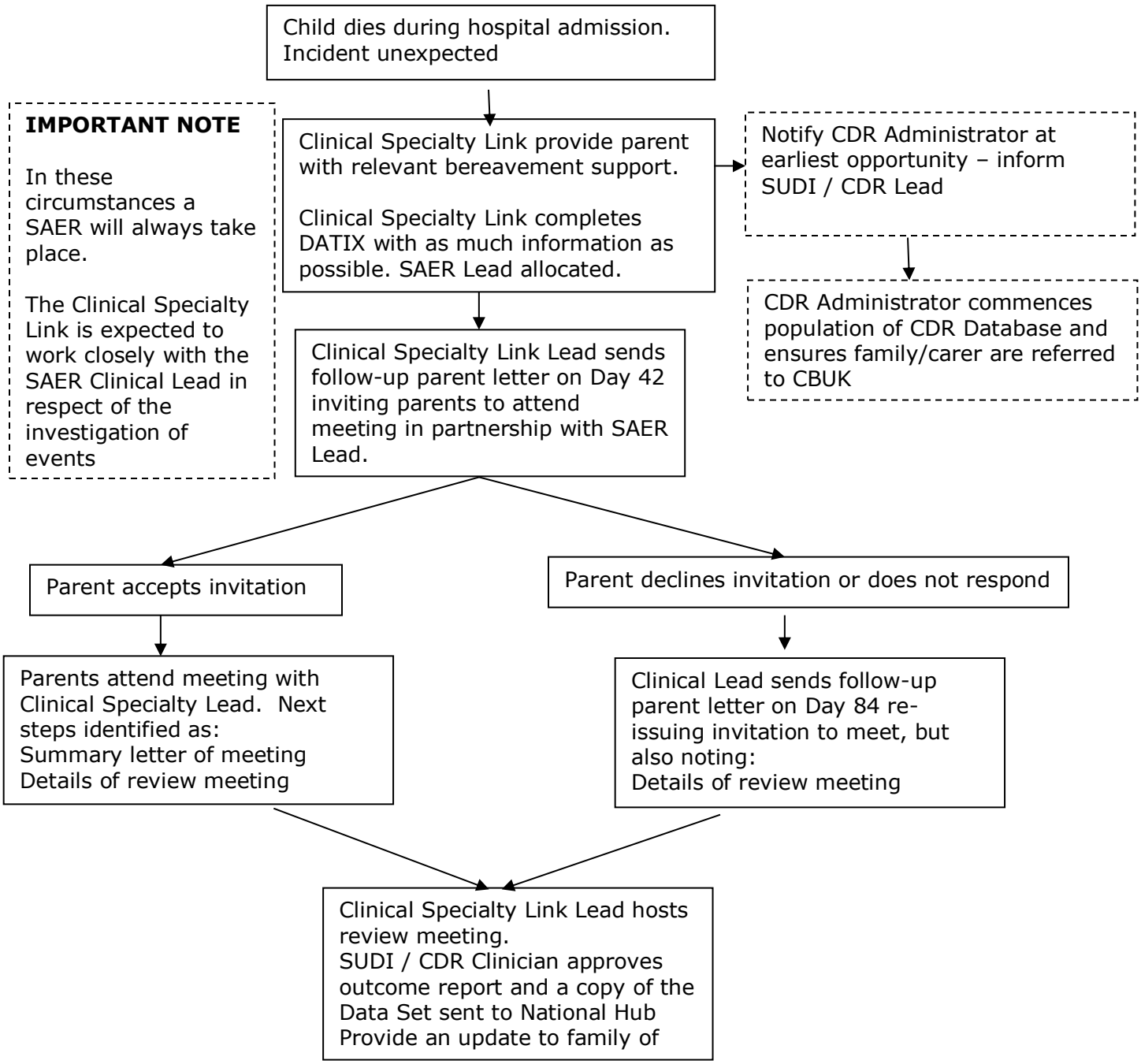
Parents attend post-event meeting with ED Clinical Lead and either SUDI or CDR Clinical Lead. Next steps identified as:
Summary letter of meeting
Details of review meeting

Parent declines invitation or does not respond

SUDI or CDR Lead sends follow-up parent letter on Day 84 re-issuing invitation to meet, but also noting:
Details of review meeting
Promise of outcome report

SUDI / CDR Clinician hosts review meeting.
SUDI / CDR Clinician approves outcome report and a copy of the Data Set is sent to National Hub
Provide an update to family of the meeting

8	Child Death in Hospital (except Neonate) - Unexpected	0– 16yrs
Responsible Service(s):	Clinical Link	
	SAER Lead	
	CDR Lead / SUDI Lead	
	Other specialties including Child Protection	



9	Death of a Child or Young Person by Suicide and known to CAMHS	0 - 18rs
Responsible Service(s):	Clinical Link	
	Head of Children's Service in relevant HSCP	
	SAER Lead	
	CDR Lead	
	Other specialties	

CAMHS Team Service Manager to notify and submit SAER Briefing note to:
CAMHS Clinical Director
SCS Administrator
Head of Specialist Children's Services
HSCP Head of Children's Services
NHSGGC Clinical Risk Dept

SCS Administrator notifies CDR Administrator at earliest opportunity of incident

CDR Administrator commences population of CDR Database and ensures family/carer are referred to CBUK

CAMHS Team Service Manager / Clinical Director to Discuss:
Staff counselling session
Initial contact with family

CAMHS team advised of death of a young person. Notify:
CAMHS Team Service Manager / CAMHS Clinical Director / HSCP Head of Children's
Complete SAE Briefing note and submit to CAMHS Service Manager / CAMHS Clinical
Enter incident details in Datix and EMIS

CAHMS Clinical Director/Head of SCS/HSCP Head of Children' Services to decide if incident to proceed to SAER

NO

- DATIX to be updated
- Local Review to be carried out
- Child Death Review Team to be notified that SAER Review will not commence
- Severity 4/5 form to be completed and returned to Clinical Risk

YES

Investigation Team (IT) appointed

Investigation Team make contact with family and advise that SAER will commence and offer opportunity to meet with the investigation team

Investigation team to notify CAMHS Team that SAER will proceed

Report to be submitted within 3 months from date of incident

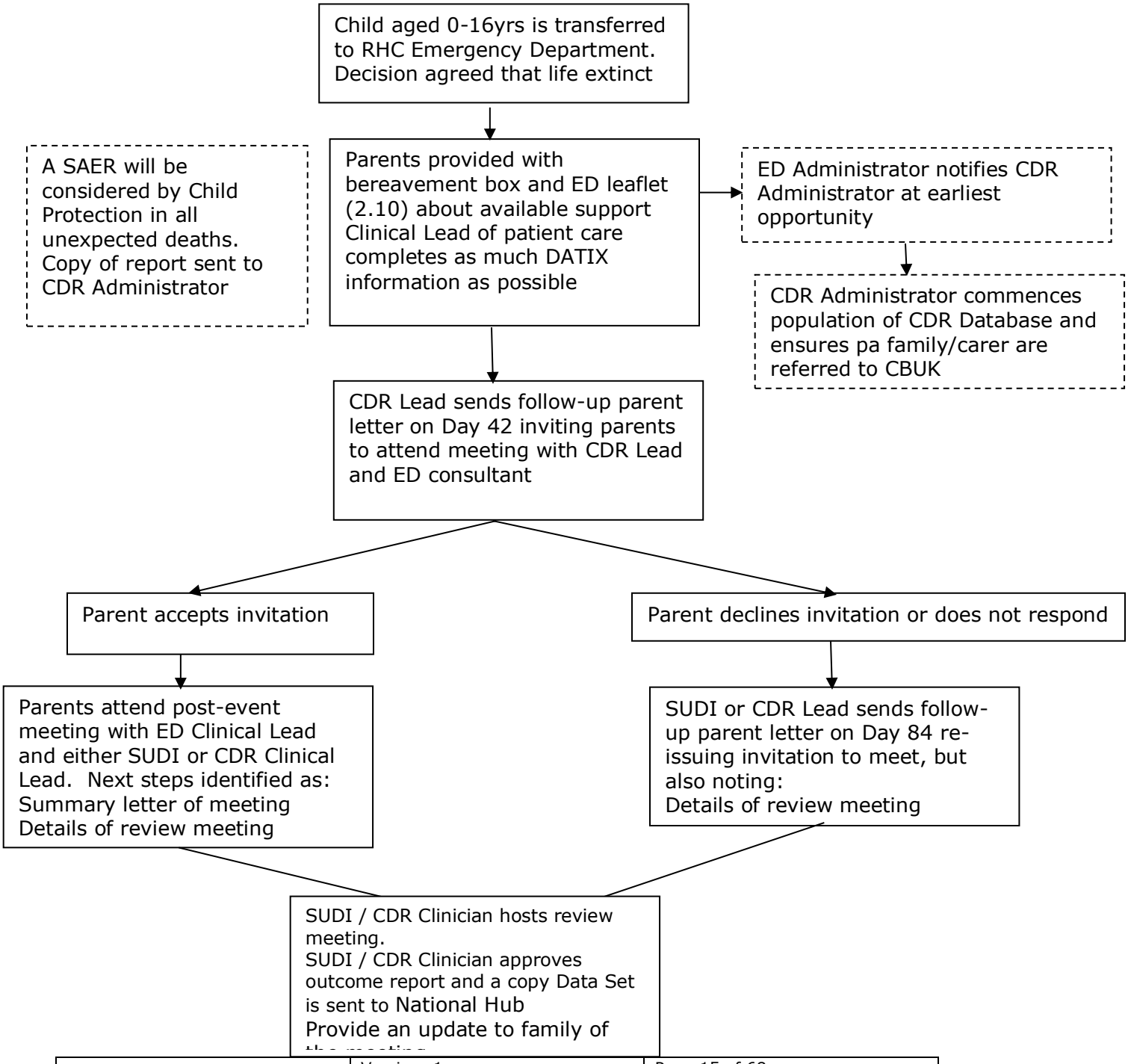
Investigation Team to discuss report with CAMHS Team for accuracy

Clinical Director/Head of SCS/HSCP HOCS to approve final SAE Report

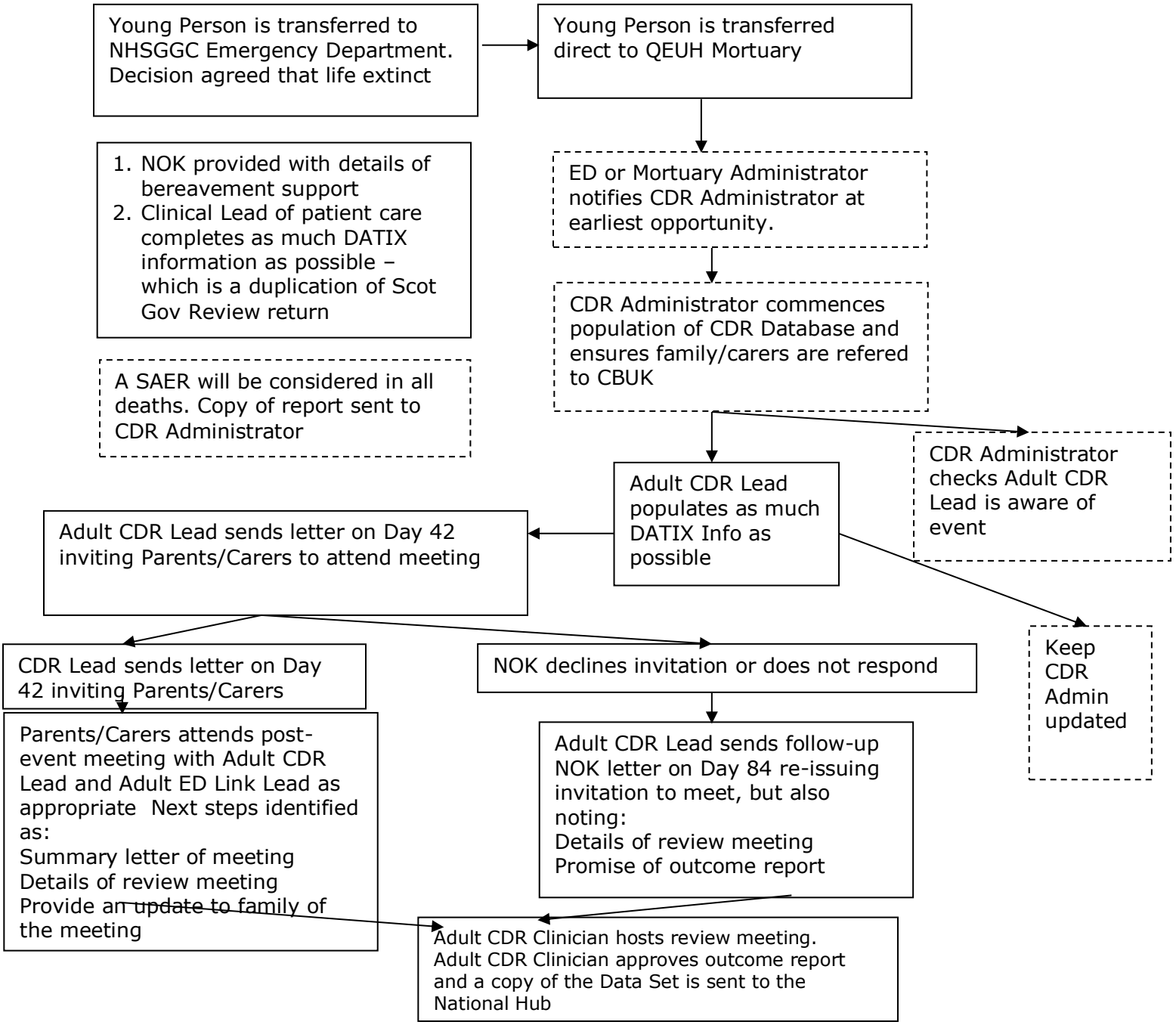
- Final report submitted to SCIREG for audit
- Investigation team to contact family and offer the opportunity to meet to discuss report.
- If family do not wish to meet they can offered a copy of the report
- Update Datix
- Send recommendations letter to teams

Send report to CDR Team

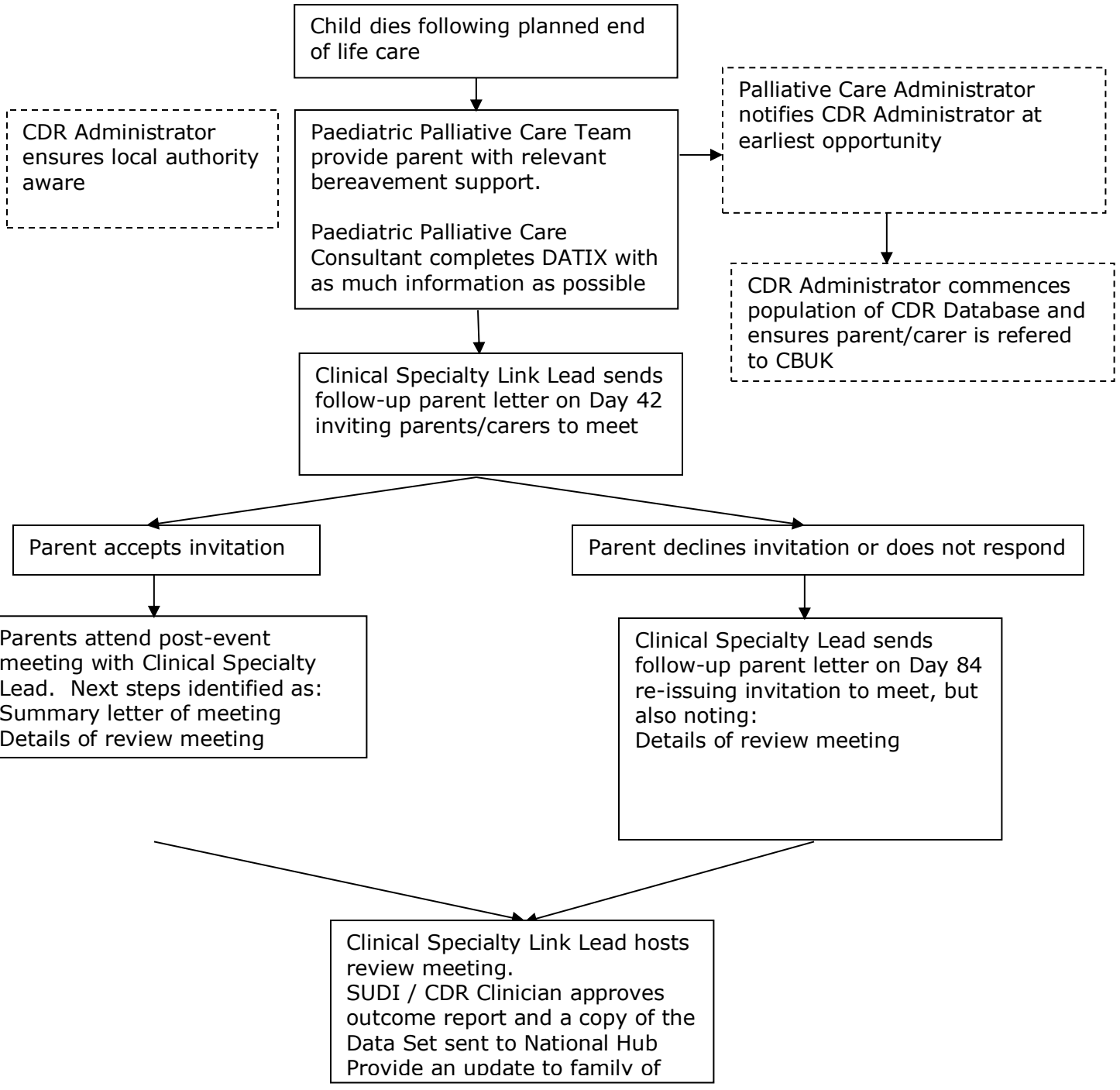
10	Death of a Child by Suicide Not Known to CAMHS	0 - 16rs
Responsible Service(s):	CDR Lead	
	SAER Lead	
	CAMHS +/- other specialties (incl. Child Protection)	



11	Death of a Young Person by Suicide Not Known to CAMHS	16 - 18rs
Responsible Service(s):	Adult CDR Lead (16-26yrs)	
	SAER Lead	
	Other specialties	

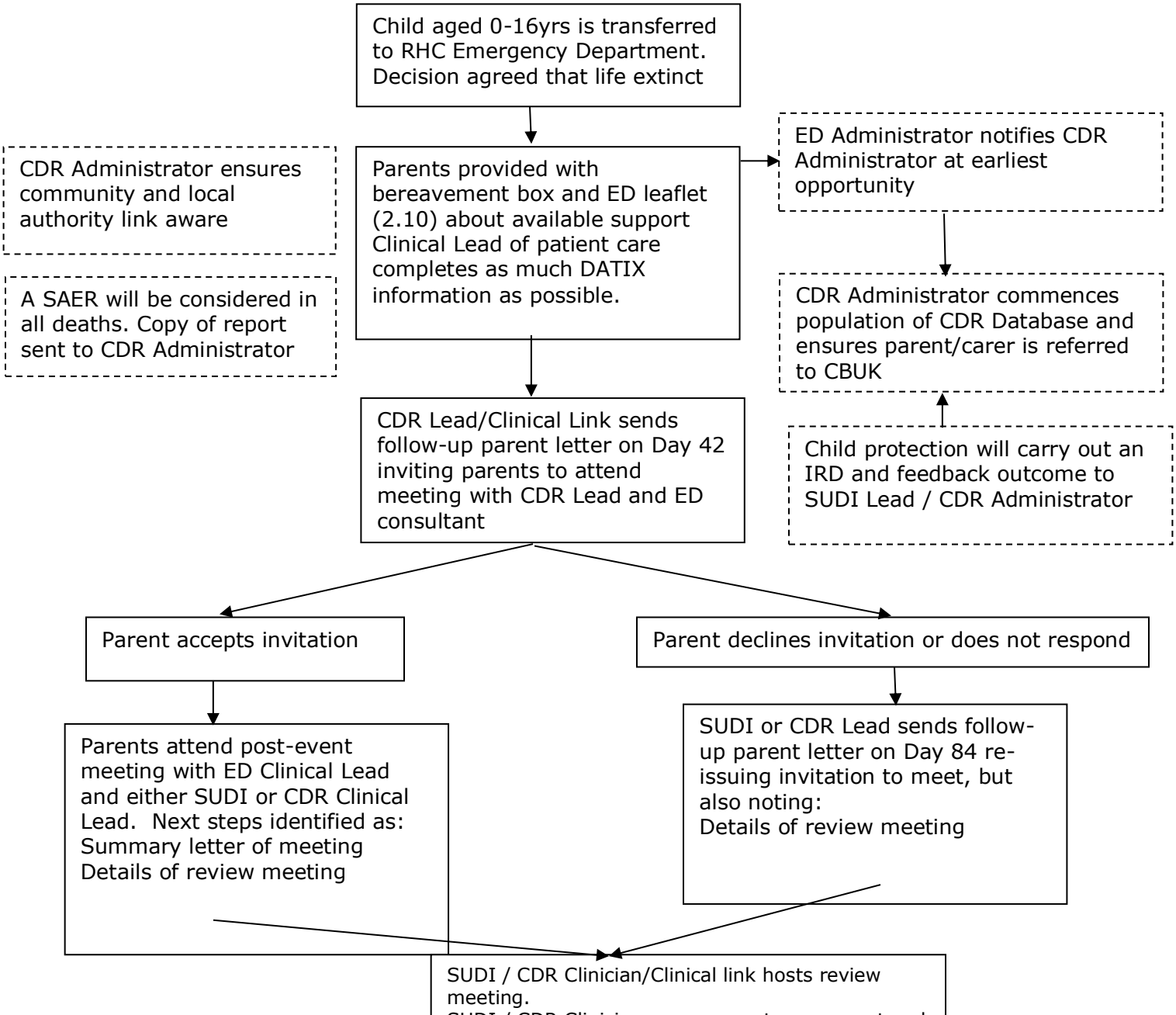


12	Child Death of an Accommodated Child Expected	0-16
Responsible Service(s):	Clinical Links Lead	
	CDR Lead / SUDI Lead	
	Local Authority / Community Link/ LAC Link / Child Protection Link	

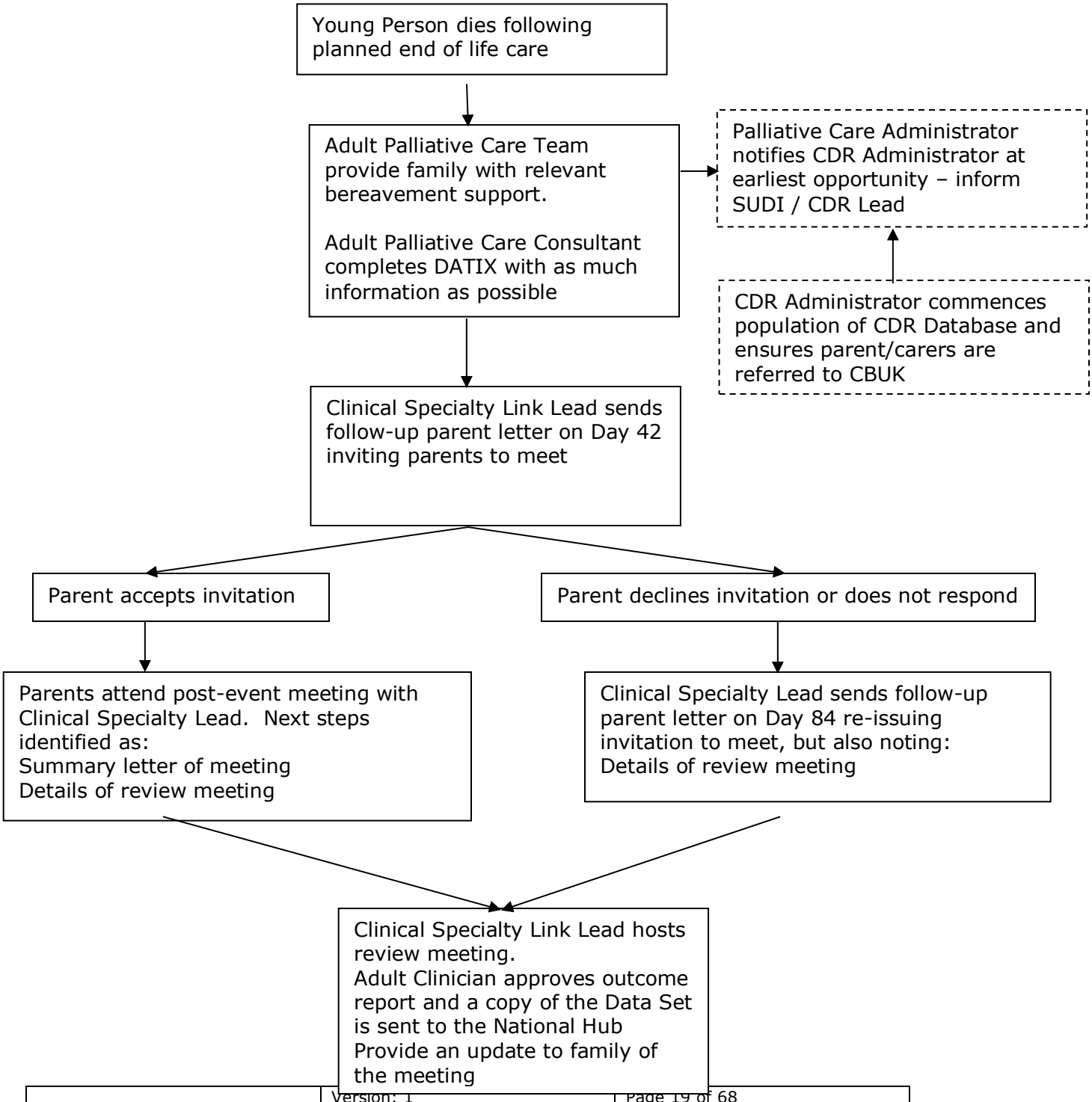


Royal Hospital for Children, Glasgow

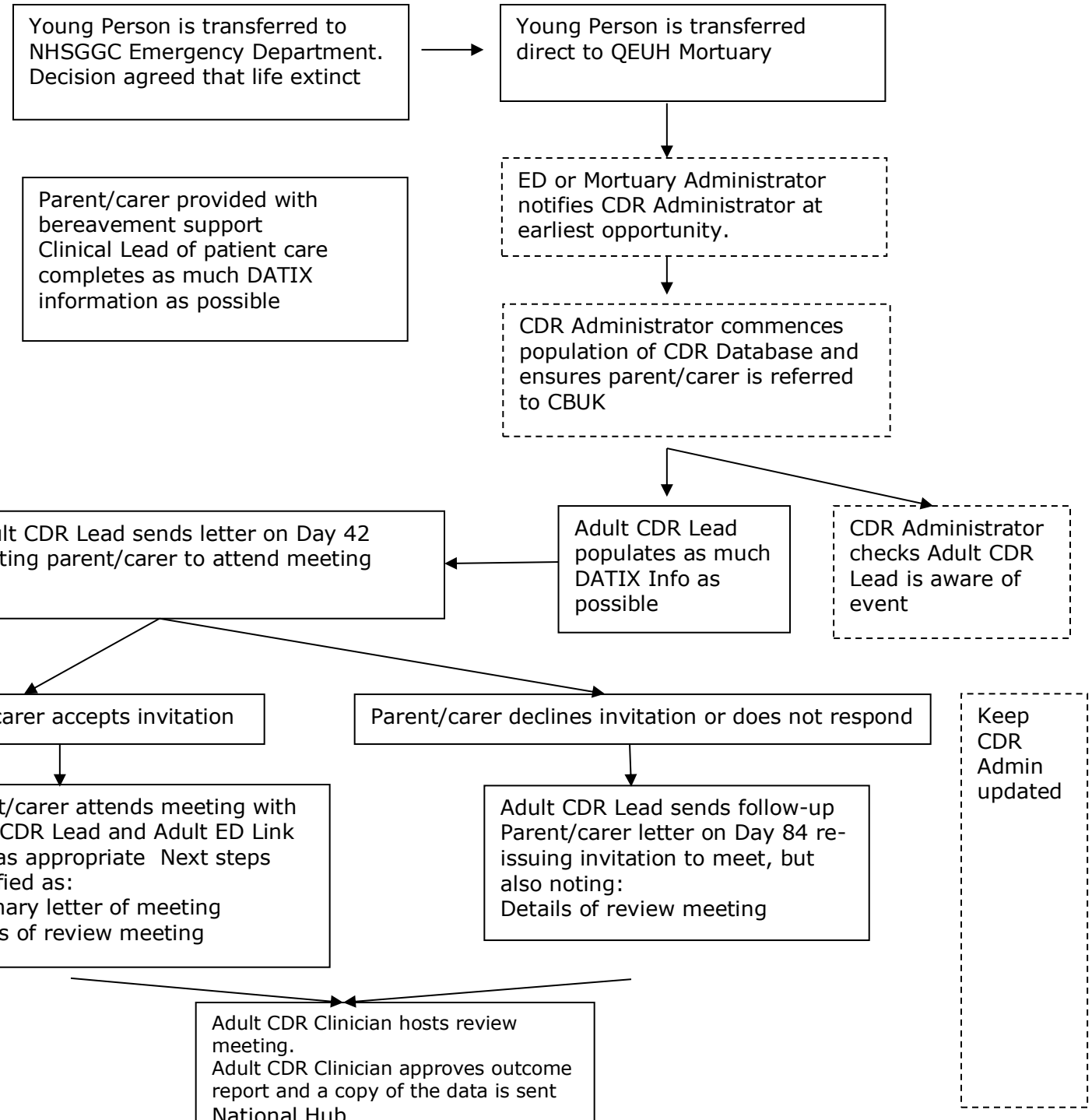
13	Child Death of an Accommodated Child - unexpected	0-16
Responsible Service(s):	CDR Lead/ Clinical Link for Accommodated Child	
	SUDI Lead	
	Local Authority / Community Link /LAC Link/ Child Protection Link	
	Other specialties	



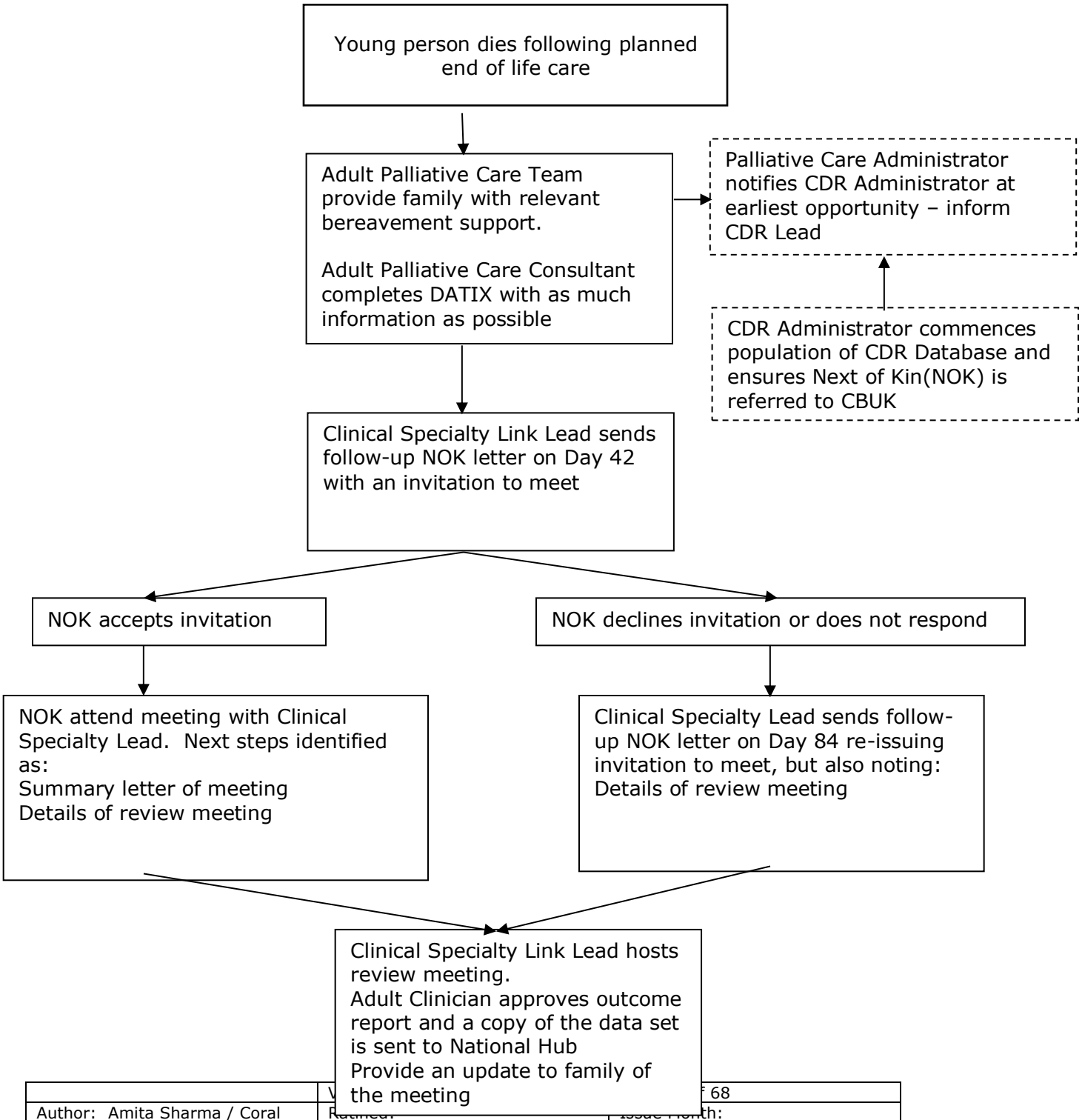
14	Death of a Young Person - Expected	16 - 18rs
Responsible Service(s):	Clinical Specialty	
	Adult CDR	
	Other specialties	



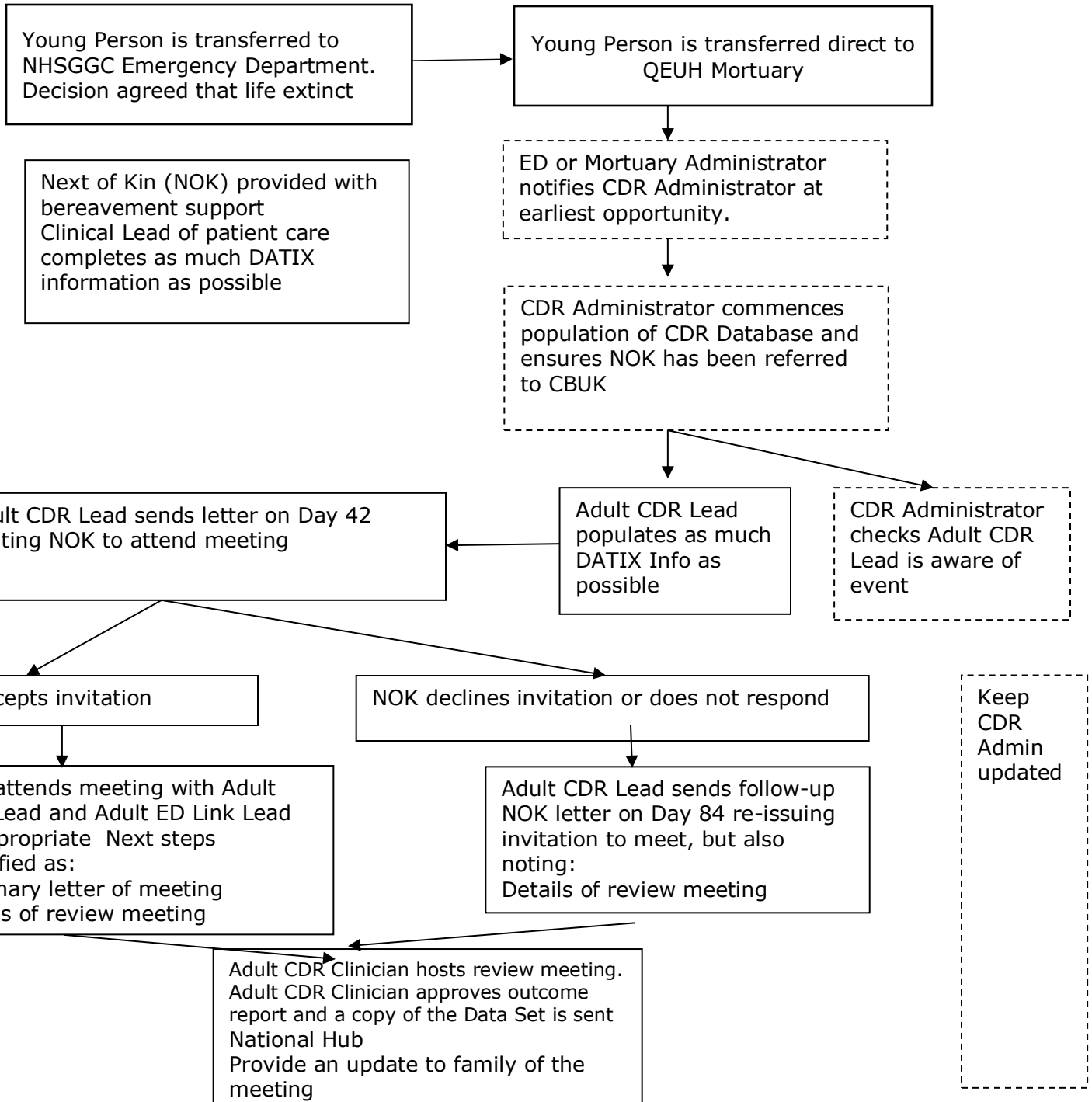
15	Death of a Young Person Unexpected	16 - 18rs
Responsible Service(s):	Adult CDR	
	Other specialties	



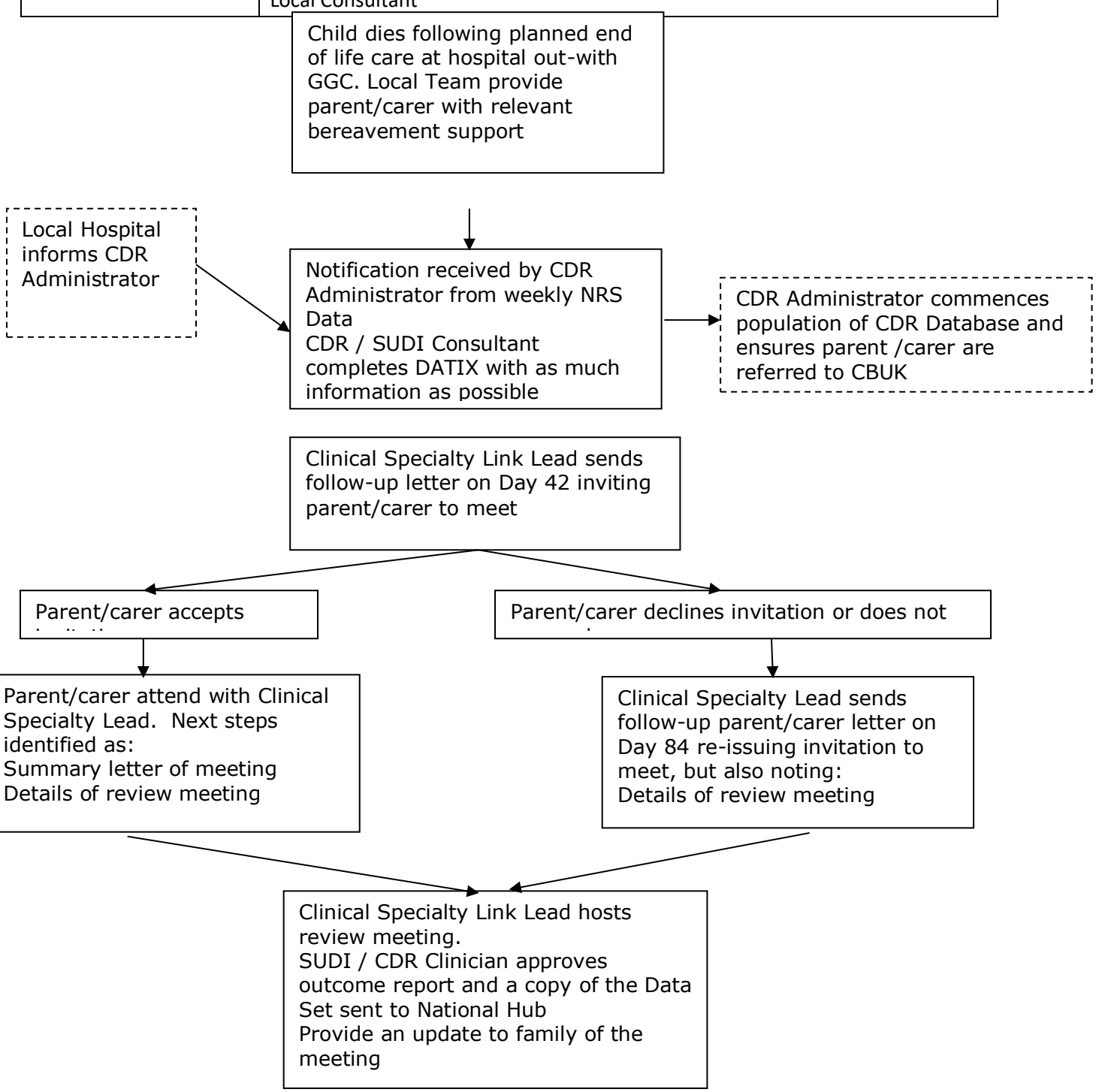
16	Death of a Looked After Young Person - Expected	18-26yrs
Responsible Service(s):	Specialty Link	
	Local Authority	
	Adult CDR 18-25yrs	



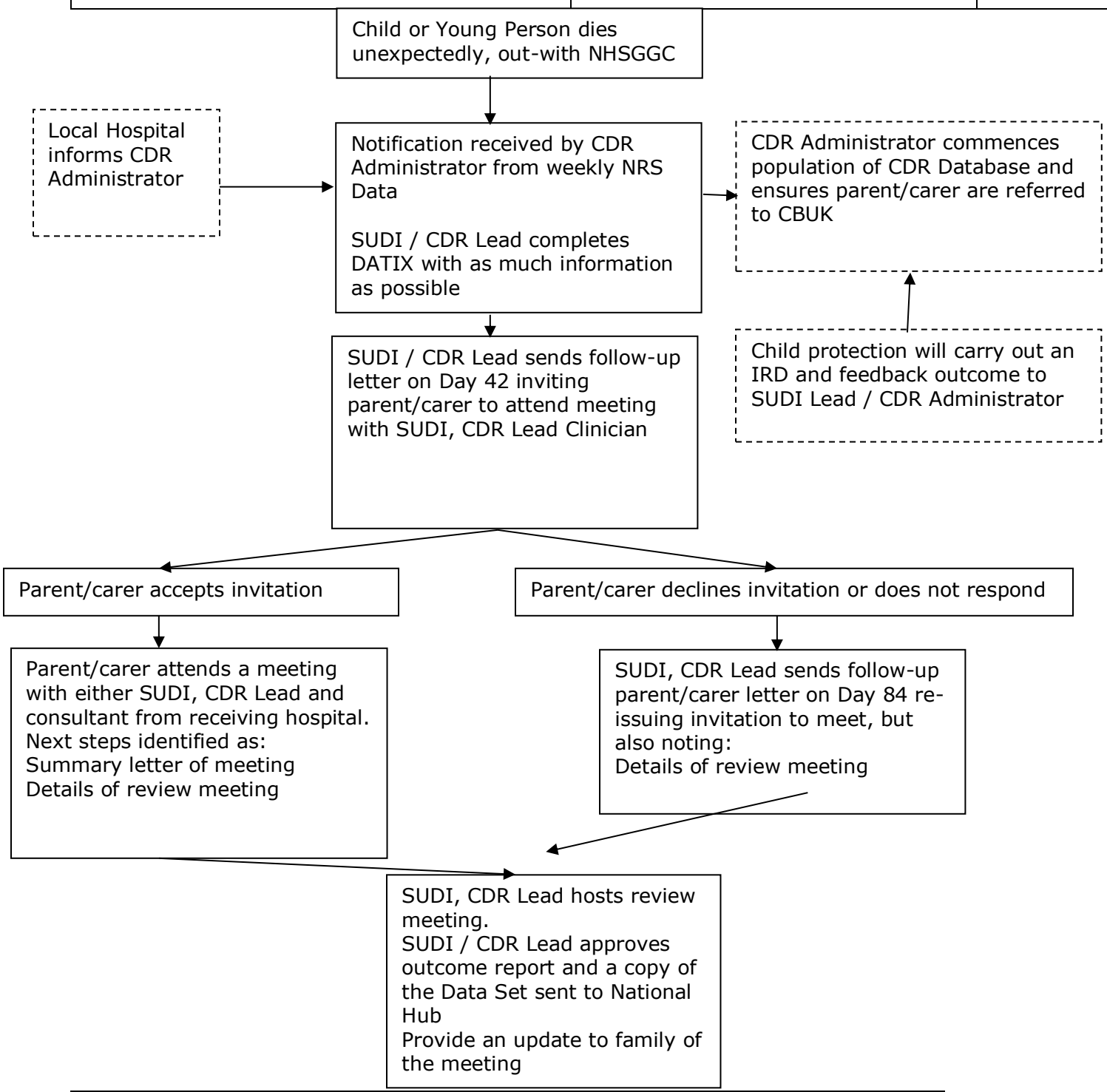
17	Death of a Looked After Young Person - Unexpected	18-26yrs
Responsible Service(s):	Local Authority	
	Adult CDR	
	Other specialties	



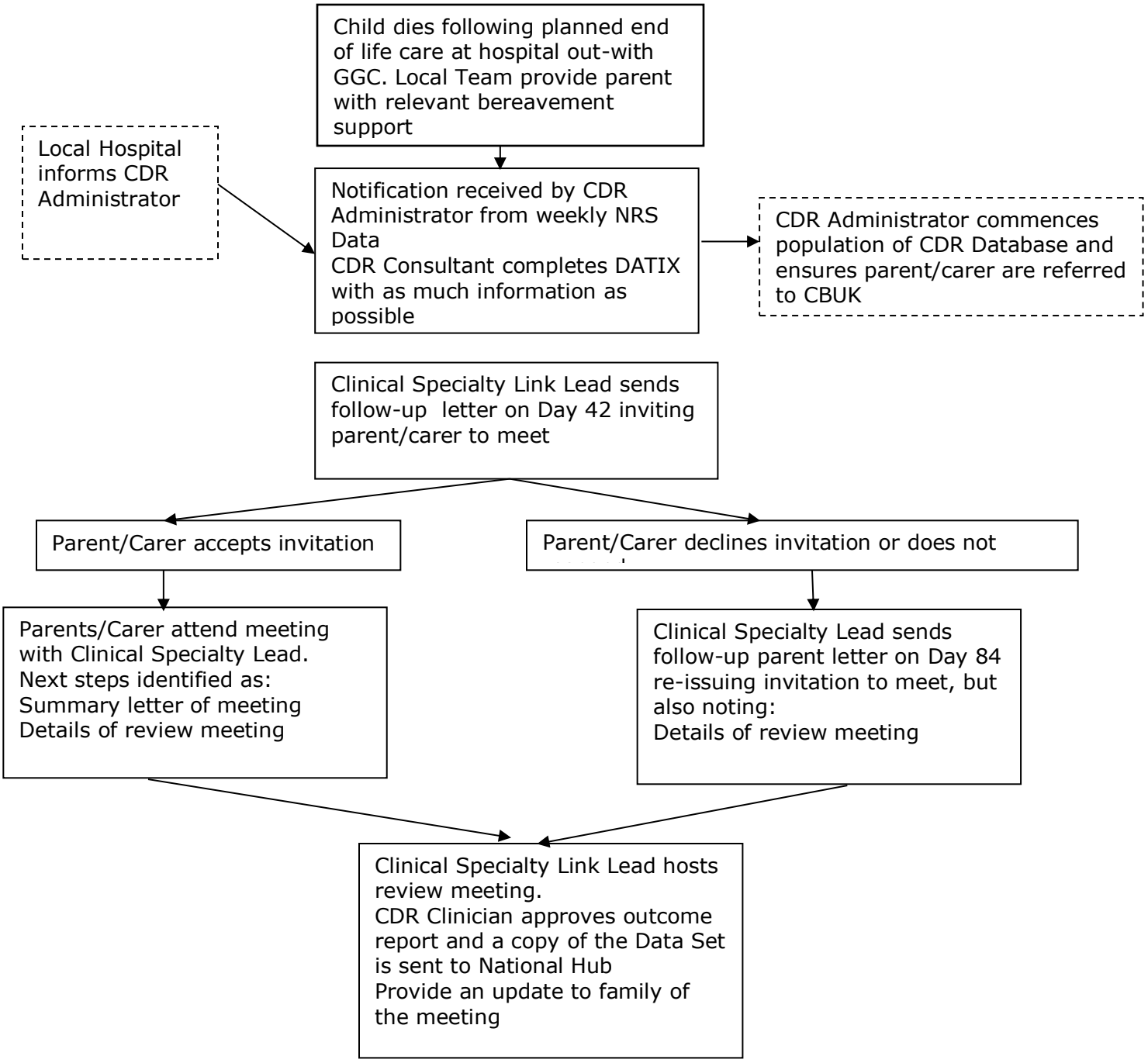
18	Death of an NHSGGC child in a non NHSGGC hospital or Hospice– Expected	0-16yrs
Responsible Service(s):	Specialty Link	
	SUDI / CDR Lead	
	Local Consultant	



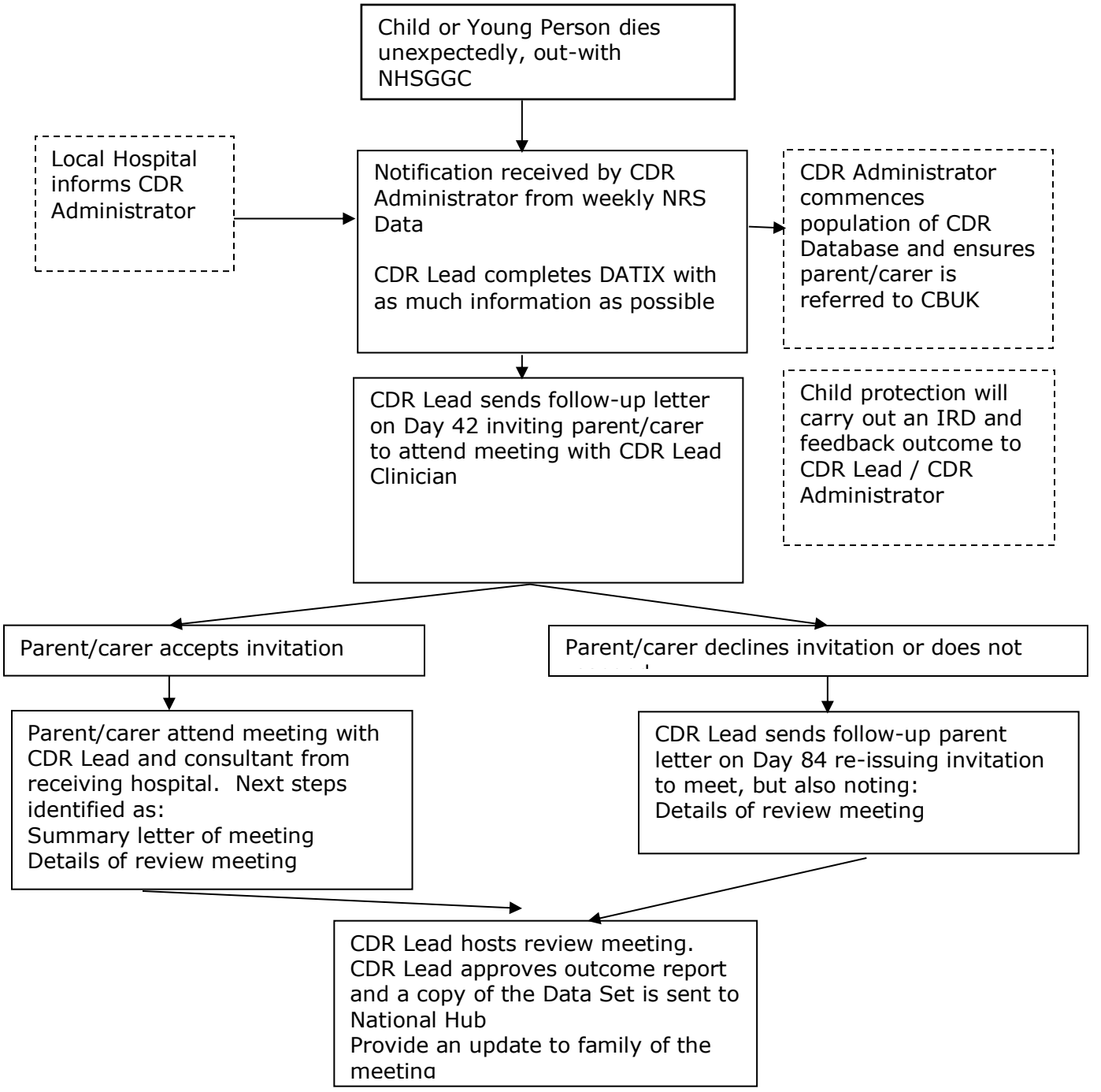
19	Death of an NHSGGC child in a non NHSGGC hospital Unexpected	0-16yrs
Responsible Service	SUDI/CDR Lead	
	Local Health Board Service	



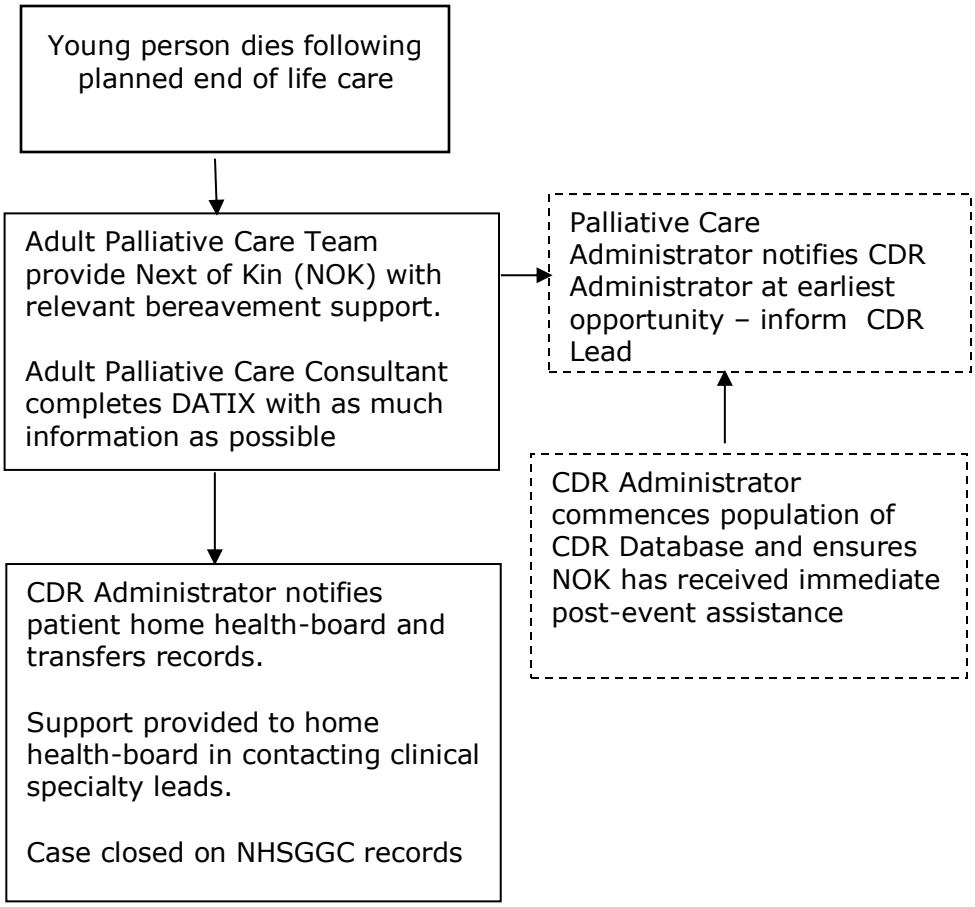
20	Death of an NHSGGC Young person out-with NHSGGC Expected	16-18yrs
Responsible Service(s):	Clinical Specialty	
	Adult CDR Lead	
	Other Health Board	



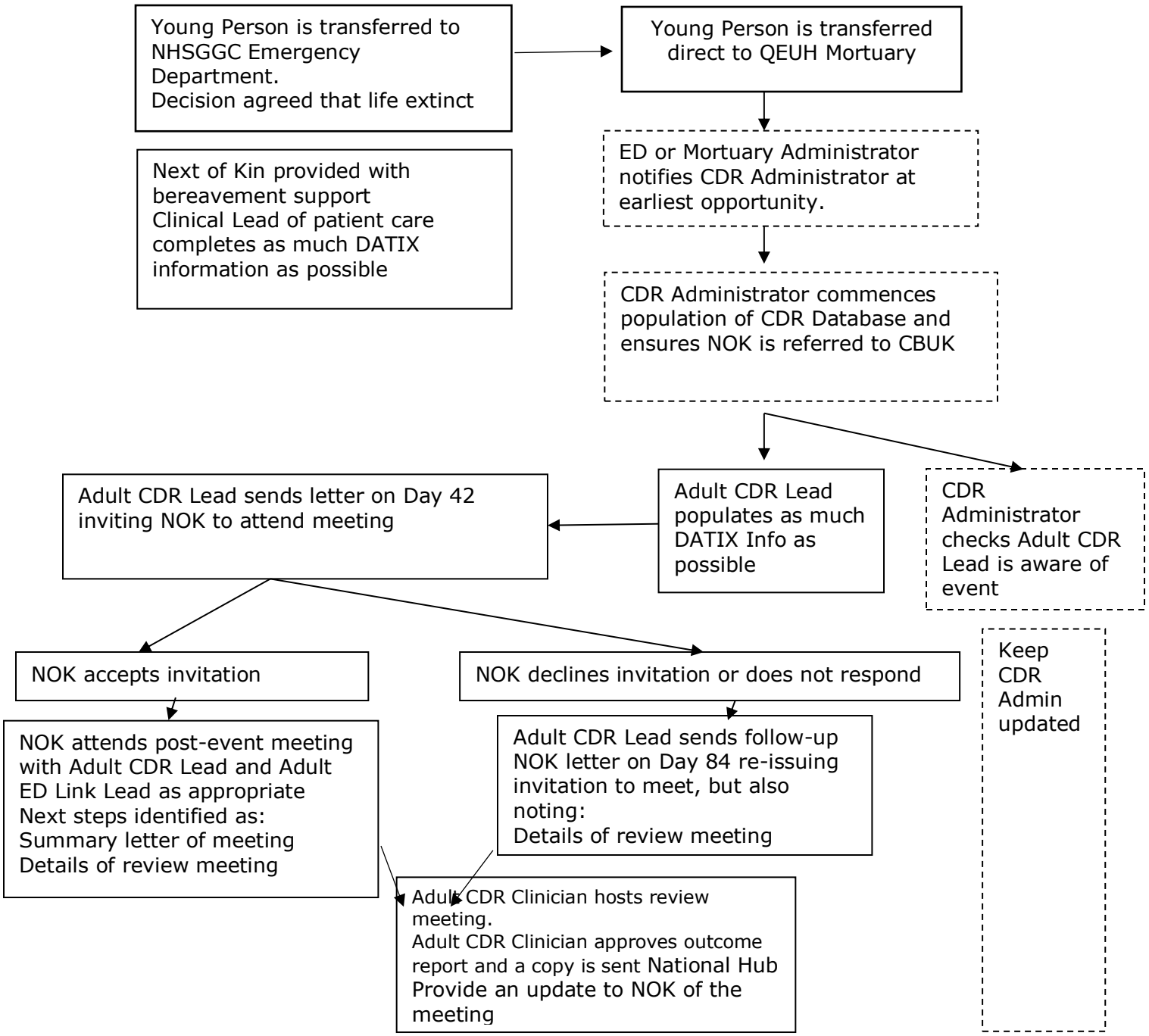
21	Death of an NHSGGC Young person out-with NHSGGC Unexpected	16 - 18rs
Responsible Service(s):	Adult CDR Lead	
	SAER Lead	
	Other Health Board	



22	Death of a Looked After Young Person outwith NHSGGC Expected	18-26yrs
Responsible Service(s):	Other Health Board	
	Specialty Services, NHSGGC	



23	Death of a Looked After Young Person outwith NHSGGC Unexpected	18-26yrs
Responsible Service(s):	HSCP Lead	
	Adult CDR Lead	
	Other Health Board	
	Other specialties	



5.2 Receipt of Notification of Child Death

- DATIX completed for all in hospital reported child deaths and received by CDR Admin Team
- Administrator enters the information onto master CDR database which is held in Child Death Review Folder, Women and Children's.
- Review National Records of Scotland (NRS) report provided by NRS on a weekly basis and enter any missing date onto master CDR database, as above.
- Collate all new cases and report to Clinical Lead(s) and Programme Lead fortnightly "Allocations" Meeting

5.3 The Allocations and Reviews Meeting

- This meeting will meet two weekly to consider all Child and Young People Deaths and on-going reviews.
- Routine attendance is expected by:
    - CDR, SUDI and Adult Clinical Lead (2 weekly)
    - Neonatal Clinical Lead (4 weekly)
    - Child Protection Link (as required)
    - CDR Administrators
    - Invited Clinical Links
- This meeting will have an agenda that will include a summary of all new deaths that have been reported in the preceeding two weeks, and any additional older deaths that may have come to light in that same period.
- In preparing for the meeting, the CDR Administrator will provide the following documentation for each case review:
    - Demographical patient information available from Portal including local authority
    - Confirmation if Acute or HSCP SAER has been commissioned
    - Confirmation of any known link to Local Authority; CAHMS or Child Protection
    - Any ED Card or Summary Report from a multi-agency service partner
    - Pathology Communications Form (if available)CDR Clinical Leads will review each new CDR case to determine the most appropriate review forum. This may be one of the following:
    - Clinical Specialty Review (for example Haemato-Oncololgy)
    - General CDR Review
- It is expected that a case discussion will focus on a summary of the events and identification of the most appropriate Lead. If the most appropriate Lead is not present at the meeting then contact should be immediately attempted thereafter and agreement sought that they will commence a review.
- Once agreed who is going to undertake the review, this information should be passed to the Administrator to update the CDR database.
- The meeting will also review all open cases and a chronological update provided by the clinical lead is expected.

5.4 Healthboard Partnership Review

Children from another health-board who die within NHSGGC

- If notification is received regarding the death of a child whose home resident is not NHSGGC, the CDR Administrator NHSGGC will immediately notify the home health-board of the event.
- The home health-board will allocate their own Clinical Review Lead and the ownership of the review will transfer to them.
- If it is identified that any relevant episodes of clinical care (whether emergent or planned) took place within NHSGGC, the clinical link for those particular departments or clinical specialties will be asked to contribute towards the review, in the same way as they would if they were contributing towards an NHSGGC review.
- A request will be sent to the home health-board to share the review with NHSGGC prior to submission and on completion.
- Learning outcomes from partnership reviews should be both measured and audited alongside NHSGGC learning outcomes.

Children from NHSGGC who die in a partner health-board

- Notification should be submitted to the central CDR email address (ggc.cdr@ggc.scot.nhs.uk)
- A request should be sent to the partner health-board for assistance in identifying a clinical link to support the review
- An NHSGGC clinical lead or link should be identified to lead the review and shared contact details will be available to all.
- On completion of the review, the report should be shared in full with the Partner Health-board

5.5 CDR Immediate Check-list

- Memory making undertaken (if requested)
- Parent Information Pack provided
- Notification passed to medical records for update of Trakcare
- Primary Care informed
- Notification to other relevant care providers (Child Protection; Clinical Specialty ; Social Work Police Scotland etc.)
- Consider if SAER indicated, if so complete briefing note to be discussed at clinical governance meeting

Administrator to update the CDR database confirming the above (as relevant) is complete. Or if not relevant, why it's not.

5.6 Parent Liaison Support

- A letter should be sent to the parent(s) from either Clinical Link or CDR Lead on Day 42 noting the following :
    - Condolence
    - Identification of a person of contact (this will be either the clinical link or the CDR Lead).
    - Invitation to meet
    - Notification regarding review process and estimated timescales.

A Day 42 Letter template has been attached at Appendix E, however, this letter is just a guide and can be individualised by the Clinical Link. Alternately if a child well known to a specific Specialty team the consultant best known to the Child and Family may want to send out initial letter arranging to meet.

Initial meeting

- Welfare check with parents and siblings
- Encourage any questions relating to the circumstances of death
- Sign-posting to additional support services
- Information update (for example pathology; other reviews)
- Information relating to the CDR process and timescales noting we will update the parent on the outcome.
- Administrator updates the database noting meeting has occurred and the date.
- Follow up letter to parent / carer from initial meeting

If the parent/carers does not respond to the Day 42 letter a further follow up letter is send on Day 84. This letter and also provides details about the CDR Review process and invites parents to submit any questions they may have.

Follow up meeting

- Letter to parent noting CDR Date and that we will update with the outcome on completion of meeting.
- Administrator updates the database noting meeting has occurred and the date.
- Meeting (if parents wish)
- Administrator updates the database noting meeting has occurred and the date.

5.7 Consideration of Established Review Processes

There are examples of review process' within NHSGGC that already exist and the CDR process does not intend to replace or dilute any of the process' but to act as a collation point for all outcome reports that relate to the death of a child. Some of the process' that exist that are an example of this are:

Serious Adverse Event Reporting (SAER)

A SAER may be commissioned regarding any death that is considered unexpected (within a specific time-frame). It will be commissioned if it is a Duty of Candour event.

In the event a SAER is commissioned, the SAER team and CDR team will work closely to ensure there is one initial contact with the family. The family will be told that a SAER will be carried out as well as a CDR report.

The SAER once complete will form part of the CDR report.

Local Learning Reviews / Local PRAMS meetings

These reviews involve the immediate clinical specialties involved in the patients' episode of care that related to the patients death. The discussion is clinically orientated and is designed to examine clinical aspects of care and what learning opportunities there may be not only for

the local team but also to be shared with other clinical colleagues (anonymously) in order to influence improvements in clinical care. The learning outcome process does not seek to examine any aspect of non-clinical care.

The Clinical Link will offer to meet the parent/carer to provide feedback and answer any clinical questions they may have.

Perinatal Mortality Reporting Tool (PMRT)

This is a national review which examines the circumstances any child who dies whilst they are receiving care within a neonatal intensive care unit.

All neonatal reviews will aim to respond to the outcome requirements of PMRT, and it will then be an administrative function to populate the CDR Dataset.

5.8 Information Governance Arrangements

All information whether in clinical format or created for database purposes relating to a patient/family member must meet the minimum standards of all GDPR and Data Protection local and national policies.

Information relating to NHSGGC Health-board Patients held on NHSGGC Systems

- Parents/carers will be notified that a CDR Review will take place and this may include information relating to the child or young persons health and social circumstances.
- Individual items of information or collated information may be routinely shared with NHSGGC staff members for the purposes of improving health care provision including educational purposes. When used for educational purposes only, all aspects of information should be carefully anonymised as much as possible.
- Individual items of information or collated information may be routinely shared with official multi-agency partners (identified through the Scottish Hub or stake-holder process) for the purposes of improving health care provision.

Information relating to non-NHSGGC Patients held on NHSGGC Systems

- Individul items of information or collated information may be routinely shared with Parent Health-board staff members for the purposes of improving health care provision NB. We would expect the parent health-board to notify the parents that they are conducting a review and that the review is cross-border and that they will be requesting information from us to complete that review.

5.9 Child Death Review Completion of Report

The CDR Coordinator is to populate the (electronic) Core Review Data Set with as much factual information as available from Trak and initial clinical reports.

The CDR Coordinator highlights which professionals are involved and gathers information on their care

Consider: Clinical specialties including Community

Primary care (EMIS)
Social care (including Looked After Services)
Police Scotland
Scottish Ambulance Services
Prison Service
Child Protection Services
Education
Pathology
Palliative Care

- Collate feedback from contributors
- Arrange meeting with professionals team (note the time limiter will be the receipt of the Post Mortem report) and / or the specialty allocated review lead for clinical service.
- Share information gathered with above review team prior to meet
- Conduct meeting
- Enter draft meeting outcomes on Core Data Set Report
- Share draft Core Data Set Report with everyone that was present
- Once approved, forward to National Hub

5.9.1 Completion of Report

How to hold an effective Child Death Review

Prior to meeting:

1. Decide on who should lead/chair the meeting and who should attend- should be multiagency eg Overall lead/Link, specialty consultant involved in care, representative form Primary care-GP/HV, Child protection/SW – who can't you do without!
2. Who will be the key worker liaising with the family and providing feedback after the meeting
3. Ensure that have the correct reports prior to the meeting- espcially if all cannot attend. The case may have undergone a SAER – important to have this information and report available. If appropriate distribute to attendees prior to meeting.
4. Ensure appropriate notice given ie 6 weeks.
5. Ensure parents are informed that the meeting will take place (not necessarily the date) and that this is a meeting for Health and Social care professionals - parents invited to contribute questions/any comments that they would like discussed at the meeting-
6. Venue where meeting to take place decided- most appropriate to allow as many people as possible to attend eg hospice, Local Authority Office, CCH offices. Video conferencing may allow more people to attend.

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.

5.9.2 The meeting:

1. Formulate and distribute Agenda
2. Welcome and introductions by chair
3. Define purpose of meeting
4. Discussion of the circumstances of the death

5. Chronology of Events- 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- draft to be circulated to members of the meeting for comments prior to submission.
9. Copy/Separate report to be sent to Health Board.
10. Consider summary letter to parents with invitation to meet with Key worker if family wish.

5.10 Local Learning Outcomes

Collate rapid review and learning points from any outcome report into a quarterly governance report that is sent to the following forums:

Women and Children's Acute Governance Forum (CDR)
NHSGGC Board Clinical Governance Forum
Acute Services Division Clinical Governance Group
Mental Health Clinical Governance Group
Primary Care and Community Clinical Governance Forum

The report will also note the number of new cases
The number of cases closed
An accumulated annual report on why the children have died (not the cause of death)
Incident prevention opportunities highlighted

Feeds into the following services:either Hospital Paediatrics and Neonatology or Adult Services Governance Forum.
Collate summary feedback to disseminate organisationally on a quarterly basis
Consider an annual educational event that looks at:

Incident Occurrence (trends analysis)
Incident prevent opportunities highlighted
Reporting process update
Recommendation outcomes
National outcomes update

5.11 Rapid Review Process

Any member of the CDR Wider Team may trigger the Rapid Alert Process. It is suggested that for the avoidance of any doubt the rapid alert should be triggered if there any cause for concern. It is preferable for the alert process to be triggered, considered and closed, than not considered.

The Rapid Alert Process should be instigated for any of the following reasons:

- A considered unusual pattern of deaths
- Any death(s) that causes exceptional concern but do not already appear to be considered by multi-agency partners

The Rapid Alert should consist of the following:

- An email with the title "Rapid Alert – Child Death Review Process"
- A summary of the reason for the alert, and if immediately available a link to any documentary evidence

The Rapid Alert should be sent to the following personnel:

CDR Clinical Links (Neonatal; SUDI; CDR and 16+)
CDR Programme Lead
CDR General Admin Email
Child Health Commissioner – Glasgow
Director, Women & Children's Directorate
Chief Nurse, Women & Children's Directorate
Child Protection Link
ED Link
SAER Links
Any relevant clinical links

The expectation of the Rapid Alert is to highlight the area of concern. Each recipient of the Rapid Alert should acknowledge receipt and identify any actions they intend to take upon receipt.

The outcome should be: No further action
Action required and what that will be

6.0 Quality Assurance Process

The Clinical Link / Lead will draft the final outcome report, in partnership with the senior CDR Administrator. A template for the report can be found at Appendix K

Once the report has been drafted, the report should be circulated to all contributors to allow for factual accuracy cross-checks.

Once all contributors have confirmed the factual accuracy of the report, the final draft should be forwarded to the Quality Assurance Lead.

The report should contain Tracked Changes and any additional outstanding queries and be returned to the CDR Lead for consideration of acceptance of changes.

Once the report has been signed off by the Clinical Link / Lead, it can be submitted to the National Hub and a further version filed on the Patients Case Record.

7.0 References

National Hub Directive https://hisportal.scot.nhs.uk/
Core Review Data Set https://hisportal.scot.nhs.uk/

8.0 Reporting and Governance within NHSGGC of the CDR Review Outcomes

It is important that there is a robust reporting mechanism around a) process set up and management and b) a review of cases and learning outcomes.
For this reason the process will have its own convened governance group that will commission and steer the overall programme (alongside HPN SAERs), and ultimately report to NHSGGC Board:

W&C CDR Governance Group
Terms of Ref (TOR)
available at Appendix A
Accountable Reporter
CDR Clinical Lead
CDR Programme Lead
(Sub Governance Groups – written reports and presentation by invitation as required)

- Acute Services Division Clinical Governance Group
- Mental Health Clinical Governance Group
- Primary Care and Community Clinical Governance Forum
- HSCP Governance Forums

Accountable Reporter
CDR Programme Lead – Quarterly written report only and presentation by invitation as requested

Clinical Leads Planning, Implementation & Review Group

Chair: Programme Lead
Monthly Programme Implementation /MonthlyRecommendations Review/ Fortnightly CDR Reviews

Working Groups

Stakeholder Group

Chair: CDR Clinical Lead
All multi-agency partners with a stakeholder interest in the development of the process and outcomes from Learning Reviews

TOR at Appendix B

Clinical Links Group

Chair: CDR Clinical Lead
All sub specialty clinical links who will be mentored and trained in how to carry out a CDR

TOR at Appendix C

CDR Partnership Working Programme

Chair: CDR Programme Lead
All CDR Leads; HSCP Representation; Child Protection; CAHMS Clinical Link for Community; Leads for Suicide and Drug Misuse

NHSGGC Team Members National Roles and Participation

CDR Clinical Lead and CDR Programme Lead
CDR Programme Lead
CDR SUDI Lead
National Clinical Leads Group
National Governance Group
RCPCH Lead

8.2 This SOP will be reviewed continuously during the soft launch phase, it will be ratified by 1st October 2021 and thereafter on a 2 yearly basis

8.3 The review will be managed by the CDR Governance Group

9. FURTHER INFORMATION/EXCEPTIONS

For further information please contact the CDR Team by email: ggc.cdr@ggc.scot.nhs.uk

10. APPENDICES

Appendix A: Terms of Reference Clinical Governance Group
Appendix B: Terms of Reference Stakeholder Group
Appendix C: Terms of Reference Clinical Links Group
Appendix D: Day 42 Letter
Appendix E: Follow up letter
Appendix F: Day 84 Unable to reach letter
Appendix G: Review Meeting Letter
Appendix H: Parent / Carer Support Leaflet
Appendix I: Professionals Reporting Feedback Form
Appendix J: Template for CDR Report
Appendix K: Quality Assurance Check-List for CDR Report
Appendix L: Post-review letter for Parents

Appendix A
Terms of Reference Governance Group

PATIENTS FIRST AND ALWAYS
Child Death Reviews Governance Group

Terms of Reference

Accountable to

Women and Children's Directorate Management Team and NHS GGC Board Governance Group.

Purpose

This group will act as a steering group in regards to implementing National Hub Death Reviews for all live born babies, children and young people aged 0-18 and looked after young people aged 18 – 26 who have an NHSGGC post-code.

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

The group will also act as a forum for implementation of the Programme and a forum in which to raise issues for discussion.

Governance

The governance of this group sits within the Women & Children's Directorate. Output from this meeting will be shared at the CDR Steering Group and CDR Links Meetings. Reports prepared will be shared as required with the Board Governance Group.

Membership

Dr Amita Sharma	CDR Clinical Lead
Dr Lynn Macleod	SUDI Clinical Lead
Dr Laura Mcglone	Neonatal DR Clinical Lead
Donna Hunter	Chief Nurse, Child Protection NHSGGC
Dr Catriona Milosovic	Child Health Commissioner, Glasgow
Jamie Redfern	Acting Director, Women & Children's Directorate
Coral Brady	CDR Programme Lead
Claire Goodfellow	CDR Administration Manager (Notes)
Elena Falanga	CDR Administration Manager (Notes)
Dr Alan Mathers	Chief of Medicine, W&C Directorate
Dr Lesley Nairn	Clinical Director, Paediatrics
Dr Graham Marshall	Clinial Lead, Primary Care

Dr George Oomman	Clinical Lead, Young Persons
Pat Tougher	GGC HCSP
Claire Fellman	HCSP
Dr Julie Metcalfe	CAHMS Clinical Lead
Dr Morag Campbell	Neontal Clinial Lead
Patricia Friel	Acting Chief Nurse , Hospital Paedatircs and Neonates
Evelyn Frame	Chief Nurse, Obstetrics and Gynaecology
Lynette Cameron	Clinial Effectiveness Manager, Clinical Risk NHSGGC
Dr Kerri Milligan	Child Protection, Clinical Lead

Responsibilities

1. To ensure an effective system is devised that will record each NHSGGC 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.

2. To identify 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.

3. To share and debate good practice specifically related to caring for children who are dying, who have died and the after care for their family.

4. To respond to current policy and guidance and disseminate as appropriate.

5. To ensure learning practices are disseminated across all accountable areas.

6. To ensure all accountable aspects to National Hub are achieved

7. To review outcome reports, debate any 'cluster' results and share learning with the wider community

Meetings

The group will meet 4 times per year (approximately every three months) for one hour. The Chair will be the clinical lead for CDR.

Minutes will be circulated by the Lead Administration Manager to CDR

Agenda items can be forwarded up to 7 days prior to meeting; however there will always be a slot for Any Other Competent Business (AOCB).

Minutes must be actioned before next committee meeting by the assigned and/or agreed individual/s.

If any member of the group is unable to attend a meeting, they should send a suitable person from their team to attend on their behalf

Communication

Following reviews of policies, guidelines and other documents, the group will agree and recommend outcomes to the Women and Children's Directorate Management Team and other operational teams.

The group will refer issues to the Directorate's Senior Management Team/ Professional Heads of Services and/or Senior Charge Nurses for further debate or implementation.

Each member has responsibility for actively informing colleagues and staff about the work of the CDR Governance Group. Group members should engage with their departments/colleagues in advance of Governance meetings to find out if there are any issues which should be addressed by the group.

The group will produce information for children, young people and their families and colleagues updating them about the work of the group.

Communication across other Sectors and Directorates will take place as required in order to progress the Child Death Review Process.

Appendix B
Terms of Reference Stakeholder group

PATIENTS FIRST AND ALWAYS
Child Death Reviews Stakeholder Group

Terms of Reference

Accountable to:
Child Death Review Clinical Governance Group

Purpose:
This group consists of multiagency representatives from Social care and Health Services representing Greater Glasgow and Clyde all of whom have an interest in ensuring that Reviews of all Child Deaths within Greater Glasgow and Clyde are carried out in a high quality standardised way that meet National Standards.
This group is accountable to the Child Death Review Governance Team (which in turn reports to NHSGGC Clinical Governance Forum).
The scope of the tem is:

1. Engagement and Involvement in the planning and implementation of the Child death review process.
2. Provide advice and guidance on the design for implementation.
3. Discuss and reach consensus on route forward.
4. Supporting the process to allow delivery of the process.
5. To continue to support future development and improvement of Service
6. Feedback any performance issues/ concerns particularly in their role as advocate for families they represent.
7. Representation of those in their own organisation whose role may be impacted by the decisions made by the process/ Health Board.
8. Feedback to the Health board on the impact of the CDR process on the communities that it serves.
9. To discuss outcomes/ summary of activity to date to inform on service improvement.

Governance

The governance of this group sits within the Child Death Review governance group.

Membership:
Clinical Lead for CDR
Clinical Lead for SUDI
Clinical Lead for 16-18's
Clinical Lead for Neonates
Programme Lead
Representation from the following (Partnership):
Police Scotland
Scottish Ambulance Service
Procurator Fiscal

Social Work
Education
Local Authorities
Representation from the following (Health):
Pathology
Emergency Department
Clinical Directors
Public health
Child Protection

Frequency Of meetings:
Bi-annual.
The Agenda will be circulated a week prior to meeting.
The meeting will be recorded and action notes will be circulated by the Chair for comment.
The Actions should be completed by the assigned member prior to the next meeting.
If unable to attend the meeting to send a representative from their team.

Communication and Feedback:
The group will refer issues to the Child Death Review Clinical Governance Group.
Each member will be responsible for feedback to their team.

Appendix C
Terms of Reference Clinical Links Group

PATIENTS FIRST AND ALWAYS
Child Death Reviews Clinical Links Group

Terms of Reference

Accountable to

Child Death Review Clinical Governance Group

Purpose

This group consists of representative from all specialties within the Hospital Paediatrics and Neonatology Directorate of NHSGGC; Acute Adult Services and Primary Care Services.

Each named individual should be interested in ensuring all Child Death Reviews that fall within an NHSGGC remit or supporting remit will be carried out in a high quality standardised manner in accordance with National Standards.

Governance

The governance of this group sits within the Child Death Review governance group.

Membership

Dr Amita Sharma	CDR Clinical Lead
Dr Lynn Mcleod	SUDI Clinical Lead
Dr Laura Mcglone	Neonatal Clinical Lead
Dr Mark Davidson	Cardiac Services
Dr Cheryl Gillies	PICU
Dr Rosie Hague	Infectious Diseases and Immunology
Coral Brady	CDR Programme Lead
Dr Andrew Barclay	Paediatric Gastroenterology
Dr Paula Beattie	Paediatric Dermatology
Ms Emer Campbell	Paediatric Neurosurgery
Dr Morag Campbell	Neonatology
Dr Shahzya Chaudhury	Paediatric Oncology/Haematology
Dr Hillary Connetta	Neonatology
Dr Ian Craigie	Paediatric Diabetes
Dr Phil Davies	Paediatric Respiratory
Dr Jonathan Downie	Paediatric Pallative Care
Dr Cliodhna Godden	Neonatology
Dr Allan Jackson	Neonatology
Dr Chris Kidson	PICU
Dr Eoghan Millar	Paediatric Ophthalmology
Dr Andrew MacLaren	Neonatology

Dr Neil Martin	Paediatric Rheumatology
Mrs Janet McCaul	Paediatric Orthopaedics
Dr Gillian Campbell	Emergency Care
Dr Lesley McKee	Neonatology
Dr Stuart O'Toole	Paediatric Urology
Jennifer Pettigrew	Paediatric Cleft Service
Dr Allyson Ramsay	Community Paediatrics
Dr Guftar Shaikh	Paediatric Endocrinology
Dr Sarah Unsworth	Neonatology
Mr Gregor Walker	Paediatric Surgery
Mr David Wynne	Paediatric ENT
Prof. Sameer Zuberi	Paediatric Neurology
Carolyn Abernethy	PRM Governance Link

Responsibilities

8. To participate in the drafting of an Standard Operating Procedure (SOP) that details the process for undertaking a Child Death Review and subsequently, once ratified uphold and follow the SOP.

9. To investigate and implement best practice training for Clinical Links, Leads and Administrators that will include Root Cause Analysis Training and Report Writing (as provided by NHSGGC Learning and Education Team / Clinical Governance Team), as well as any training available from other Nations who have already implemented similar process'.

10. To champion the utilisation of DATIX to ensure each death of a child is reported via this mechanism.

11. To make themselves familiar with the process' required within a CDR (by reading the SOP, accepting mentorship from an experienced clinician) and to discuss the process and any positive / negative experiences following the implementation of a process, with a view to continuous improvement.

12. To represent your Department in undertaking a Child Death Review in a manner which ensures the review is accurate, timely and presentable.

13. To assist in the drafting and participation of all family communications (including Day 42 and Day 84 correspondence) as well as updating the family (in partnership with your nominated administrator) in terms of Review progress.

14. To work with multi-service services (such as bereavement support) to ensure families receive the best support we are able to provide.

15. To work with multi-agency representatives (in partnership with your administrator) to create a Review Team who will participate in the eventual Child Death Review (see draft SOP), and share those experiences' with this Forum.

16. To manage a Child Death Review Meeting.

17. To draft a CDR Outcome report that is factual and timely.

18. To report on the outcome of a CDR to local (departmental and / or NHSGGC CDR Learning Event) and as required national CDR events with the purpose of sharing learning outcomes.

Meetings

The group will meet 2 times per year for one hour. The Chair will be a member of the Child Death Review Team, the SUDI Lead is proposed as the Chair for the first formal meeting.

Minutes will be circulated by the Senior Administrator to CDR

Agenda items can be forwarded up to 7 days prior to meeting; however there will always be a slot for Any Other Competent Business (AOCB).

Minutes must be actioned before next committee meeting by the assigned and/or agreed individual/s.

If any member of the group is unable to attend a meeting, they should send a suitable person from their team to attend on their behalf

Communication

The group will refer issues to the Child Death Review Clinical Governance Group.

Each member has responsibility for actively informing colleagues and staff about the work of the CDR Clinical Links Group. Group members should engage with their departments/colleagues in advance of meetings to find out if there are any issues which should be addressed by the group.

Appendix D
Day 42 Letter {remove header prior to sending} v1

Patient Services Department
Royal Hospital for Children
1345 Govan Road
Glasgow
G51 4TF

Our Ref: CHI Number
Date: DD Month 2021
Our Tel: 07929 659967
Our Email: ggc.cdr@ggc.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

It is with deepest condolences that I am contacting you following the sad death of your (relationship), (first name). We realise that this letter comes at a very difficult time for you and your family.

I appreciate that you and your family may have some outstanding questions and I would like to offer to meet with you.

A team of multiagency professionals is working together 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. I will be your key worker for this review so please feel free to contact me at any time.

If you would like to meet please contact our Administrator either by phone on 07929 659967 or via email childdeathreviewservice@ggc.scot.nhs.uk and we will arrange a meeting. Due to Covid-19 restrictions, you may wish this to take place virtually, and we can organise this. You may feel that meeting right now is too soon, please do contact our Administrator if you wish to meet at any time in the future that is best for you.

I would like to ensure that you have been offered bereavement support. Please find enclosed a leaflet from Child Bereavement UK. You can either contact them directly or if you would prefer we would be happy to refer you and your family.

Once again, I am deeply sorry for the loss of your (relationship), (first name).

Yours sincerely

Clinical Lead

Appendix D
Day 42 Letter {remove header prior to sending} v2

Patient Services Department
Royal Hospital for Children
1345 Govan Road
Glasgow
G51 4TF

Our Ref: CHI Number
Date: DD Month 2021
Our Tel: 07929 659967
Our email : ggc.cdr@ggc.scot.nhs.uk

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

Dear Mr and Mrs

Help and Support for You & Your Family

I am so very sorry to learn of the death of your (insert relationship), insert name. I can't imagine what you and your family are going through just now.

I am [insert job title] and I am responsible for [insert what you do] when a **baby or child** dies suddenly. I will be your point of contact moving forward as there are some processes that we have to go through when a **baby/child** dies in Scotland.

I wanted to introduce myself and also tell you about support that is available for you and your family.

My contact details

You can contact me on [insert contact details], if you ever want to discuss things with me or if you have any questions. I will do my best to answer any questions that you have. If I can't answer them immediately I will certainly do my best to find the answers for you.

Offer to Meet

I would like to give you the opportunity at this time to meet in person so that you can ask any questions that you have at this time. We could meet face to face, or virtually or by telephone if you would prefer. I do however understand if you don't want to meet at this time and this is an open ended invitation. I can appreciate that you may feel overwhelmed so please be reassured that I am happy to take things at your pace.

If you would like to meet please contact our Administrator either by phone on 07929 659967 or via email ggc.cdr@ggc.scot.nhs.uk and we will arrange a meeting.

Support for you

I wanted to let you know about some Bereavement Support that is available for you in addition to the support I can offer you. There are several charities who provide bereavement support which can take various forms including:

- Peer support (known as Befriending) where you are linked with another bereaved parent,
- Counselling (some charities offer 6-8 sessions, others offer more if you would like more),

- Support groups (where you can meet other bereaved parents. These can be virtual or face to face).

I have referred you to Child Bereavement UK who I hope have been in touch already. They will also be able to refer you to other support services.

Please know that you and your family don't need to go through this alone.

.

Next Steps

As you know, a Post Mortem examination has been carried out to try to help us understand why (insert name) died. It can take many months for the results of the Post Mortem results to come back (over 12 month) due to the complex nature of the tests that are carried out. Once the results of the Post Mortem are back, we have to hold a Review which is attended by all of the professionals who were involved in (insert name's) death. This is known as a Child Death Review and we try to gather as much information about why your *(baby/ child)* died. You will be given an opportunity to participate in this review by sending in any comments and questions that you have. I will be your point of contact for the Review and I will let you know when this is going to take place. Some families find it useful to write down any questions that come to mind in the months following their child's death as this can help them with their questions when it comes to the review.

Please don't hesitate to contact me if you have any questions or if you would like to meet. I am here to support you at this terrible time.

Yours sincerely

Clinical Lead

Appendix E
Follow Up Letter {remove header prior to sending}

Patient Services Department
Royal Hospital for Children
1345 Govan Road
Glasgow
G51 4TF

Our Ref: CHI Number
Date: DD Month 2021
Our Tel: 07929 659967
Our Email: ggc.cdr@ggc.scot.nhs.uk

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

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 enclose 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 18 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 collate 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 telephone number or email address above.

Royal Hospital for Children, Glasgow

Patient Services Department
Royal Hospital for Children
1345 Govan Road
Glasgow
G51 4TF

Yours sincerely

Our Ref: CHI Number
Date: DD Month 2021
Our Tel: 07929 659967
Our Email:

Clinical Lead

Summary of Meeting Letter {remove header prior to sending}v2

NHS Greater Glasgow and Clyde

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

Dear Mr and Mrs

Summary of Our Meeting on [insert date]

Thank you very much for taking the time to meet with me and my colleague [insert name]. I appreciate how difficult it was for you to come and speak with us. At our meeting, we spoke about lots of things and you had some questions for me. I said that I would do my best to find the answers for you and I am now writing to summarise both your questions and the answers we were able to give you.

We spoke about the following:

- Bullet Points
  Your question:
  Our Answer:

I know nothing we can do or say will lessen the pain your family are in but I hope that our meeting helped by answering the questions you had at that time. If you have any more questions then please get back in contact with me.

Next Steps.

As I have mentioned previously, 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. I will also let you know when the review is due to take place and give you another opportunity to give any more comments or ask any more questions. You can do this in your own format or you can use the enclosed form which might help you gather your thoughts. You don't need to use this form if you don't want to. .

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 18 months. We will provide you with an update as to any progress.

Once the review has taken place, a report will be produced to summarise the review findings and we can meet to discuss those if you would like to. You can also discuss this with your GP, who will also have a copy of the report if you would be more comfortable doing that.

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 collate information on all children who have died in Scotland.

At our meeting, we also spoke about some bereavement support for you and we discussed what support is available. Please let me know if you would like me to refer you on to any of the charities who can help.

I will be in contact when I have more information to share with you. However, don't hesitate to contact me in the meantime if you have any further questions.

Yours sincerely

Clinical Lead

Appendix F Day 84 Unable to Reach v1
{remove header prior to sending}

Patient Services Department
Royal Hospital for Children
1345 Govan Road
Glasgow
G51 4TF

Our Ref: CHI Number
Date: DD Month 2021
Our Tel: 07929 659967
Our Email: ggc.cdr@ggc.scot.nhs.uk

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

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 ggc.cdr@ggc.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 number or email above.

Yours sincerely,

{Name}
Clinical Lead

D84 Unable to reach letter v2

Patient Services Department
Royal Hospital for Children
1345 Govan Road
Glasgow
G51 4TF

Our Ref: CHI Number
Date: DD Month 2021
Our Tel: 07929 659967
Our Email: ggc.cdr@ggc.scot.nhs.uk

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

Dear [*insert parent or parents' name*]

I am following up on my letter of (date). I was very sorry to learn of the death of your baby/child (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 a very important part of the review 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 will talk you though what happens at the Review and will support you to collate your questions and thoughts, if you feel this would be helpful.

I have enclosed a parental contribution 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
- any other questions you may have

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

It may take over a year for the Review meeting to take place. I appreciate that this will feel like a very long time however the reason we wait for this time is to make sure we have all the necessary information available and that the right professionals can attend. You will not be asked to attend the meeting in person.

I will let you know when the Review meeting is going to take place in case you have any further questions or comments.

If you have any questions about this letter please do not hesitate to contact me on the number or email above.

I have also included with this letter information from Child Bereavement UK who can support you.

Yours sincerely,

[*Name*]
Child Death Review Team

Attachment to Day 84 Unable to Contact Letter – remove this header before sending Parent / Carer Contribution Form

Contribution 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 this 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, Royal Hospital for Children, Office Block, 1345 Govan Road, Glasgow, G51 4TF or email at ggc.cdr@ggc.scot.nhs.uk

Care prior to your child being taken to the emergency department • Please use this section for comments on and questions about the care of your child prior to be taken to hospital
Care in the emergency department • Please use this section for comments on and questions about the care received within the emergency department

The care of you and your family afterwards

- Please use this section for comments on and questions about care after you left the hospital

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

Appendix G Review Meeting Letter {remove header prior to sending}

Patient Services Department
Royal Hospital for Children
1345 Govan Road
Glasgow
G51 4TF

Our Ref: CHI Number
Date: DD Month 2021
Our Tel: 07929 659967
Our Email: ggc.cdr@ggc.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,

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

Appendix I
Professionals Feedback Questionnaire

CDR PROFESSIONALS QUESTIONNAIRE

1. Child/Young Person Demographics

Demographics	
Child/Young Person's Name:	**CHI Number :**
Date of Birth :	**Date of Death :**
Address:	**Postcode:**
Mothers Full Name:	**Fathers Full Name:**
Number of Siblings :	**Is this a looked after Child/Young person?**
	Yes/No

2. Professional Details

Professional Details	
Name:	**Profession:**
Address:	**Postcode:**
Email Address:	**Contact No:**

When completing the following questions can you please complete each of the sections below. Please use the indicators below to determine the different levels of influence (0-3) for any identified factors:

0 Information not available
1 Factor not identified
2 Factor identified but unlikely to have contributed to vulnerability, ill-health or death
3 Factor identified that may have contributed to vulnerability, ill-health or death

This information should inform the learning of lessons at a local level.

3. The Child/Young Person

Please provide details of the child/young person's environment, in particular to understand factors in relation to the care of the child/young person that may have had relevance to the death

Factors intrinsic to the child/young person – Please select all that you are aware of	**Level of influence 0-3**
Pre-existing medical conditions (including any congenital anomalies or disability)	
Developmental impairment or learning disability	
Mental health conditions or emotional difficulties	
Smoking (including vaping)	
Drug misuse	
Alcohol misuse	
Gender identity	
Social relationship issues	
Factors intrinsic to the child/young person: Please provide relevant details relating to the sections above and also consider other known health needs; factors influencing health; growth parameters development/educational issues; behavioural issues; social relationships; identity and independence; any other identified factors in the child/young person.	
[free text]	

4. Family and Social Environment

Please provides details of the child/young person's environment. This will allow us to understand factors in relation to the care of the child/young person that may have had relevance to the death

Adverse childhood experiences and other factors – Please select all that you are aware of in relation to the social background of the child/young person	**Level of influence0-3**
Emotional abuse	
Physical abuse	
Sexual abuse	
Household domestic abuse	
Neglect	
Parental separation	
Household mental illness	

Household alcohol abuse	
Household drug use	
Household member incarcerated	
Household member known to police	
Household physical health issues	
Household disability (including learning disability)	
Bereavement within immediate family	
Bullying	
Household poverty	
Exposure to second-hand smoke	
Factors in social environment: Please provide relevant details of any additional factors if relevant/known: family structure and functioning; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment. Include strengths as well as weaknesses.	
[free text]	

5. Physical Environment

Please provide details of the physical environment in which the child/young person was living or died, including any issues in relation to housing, the built environment and environmental safety.

Factors relating to the physical environment of the child/young person – please select all that you are aware of	**Level of influence 0-3**
Home safety	
Neighbourhood safety	
Poor quality housing/homelessness	
Household overcrowding	
Other physical environment safety issue	
Factors relating to physical environment: Please provide a description of any relevant environmental factors known to you that have not been covered elsewhere. You might consider issues relating to the physical environment the child/young person was in at the time of the event leading to death, or the mother during pregnancy, including: poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g. burns, falls, road traffic collisions, drowning).	
[free text]	

6. Additional Information

Please provide any additional information which you feel may be relevant to the Child Death Review process such as copies of reports etc

Additional information
[free text]

Once you have completed this questionnaire please return it following email address: ggc.cdr@ggc.scot.nhs.uk

If you have any questions regarding the questionnaire then please contact the Child Death Review Team on 07929 659967

Royal Hospital for Children, Glasgow

Patient Services Department
Royal Hospital for Children
1345 Govan Road
Glasgow
G51 4TF

Our Tel: 07929 659967
Our Email: ggc.cdr@ggc.scot.nhs.uk

Appendix J
Template for the CDR Report

Report Author:
Report Administrator:
Contact Email:

Sudden Unexpected Death of Infant (SUDI) Review Report
or Child Death Review Report
or Young Persons Death Review Report

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**

Documents considered at the Meeting:

Date Received	**By Whom**	**Organisation**

Section 1: The Purpose of the Review

1. To ascribe a final cause of death and of any relevant associated factors
2. To consider the ongoing support needs of the family and/or siblings
3. To consider relevant plans for supporting any potential future pregnancies
4. To consider any points of communication for the family
5. To consider any factors which are potential learning opportunities for NHS Scotland and in particular Greater Glasgow and Clyde in the context of this death event

There will be an agreement on a named professional to provide feedback and a follow-up with the family after the TYPE OF REVIEW, in this instance it is NAME.

The family will not attend the review; however they will be given the opportunity to feedback and express their own views to the named person during the discussion about the review.

The TYPE OF REVIEW provides an opportunity to document learning opportunities for professionals based on their own experience through involvement with the INFANT / CHILD / YOUNG PERSON and his/her family and address any concerns or issues that the family may have raised.

The purpose of this particular TYPE OF REVIEW meeting was to discuss all aspects surrounding the death of CHILD'S NAME including possible contributory factors in order to identify any preventable or modifiable factors and to discuss any lessons can be learned. It was also in order to provide ongoing support and care for the family.

MEETING LEAD NAME (Chair) welcomed all participants, explained the nature of the review process and the intended outcomes from meeting. All participants were invited to contribute.

Section 2: Family Involvement

	Name	**Age**
Mother		
Father		
Sibling (delete as applicable)		
Sibling		
Sibling		

- Pre-Meeting contact
- Family dynamics
- Any ethnicity considerations / language considerations etc.
- Questions the Family Wish to Ask
- Any other relevant information

Section 3: Background

- Pregnancy
- Social-work
- Education
- Home situation
- Parents health etc.

Section 4: Detailed Description of Events

4.1 Chronology of Events

4.2 Interventions / Resus Attempts etc.

4.3 Post Mortem

Section 5: Multi-Agency Updates on Events To Date (not already incorporated above)

Section 6: Post Event Family Support / Pastoral Care

Include future pregnancy care if relevant

Section 7: Learning Points across NHSGGC / Multi-Agencies / Scotland

Consider SMART learning points
Specific (who and what)
Measurable
Achievable
Resource Requirements
Time for Implementation

Section 8: Conclusion

Brief summary of circumstances, events and outcome

Section 9: Governance

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

This report was quality assured by NAME OF ASSURER on DATE.

A copy of this report will be distributed as follows:

Scottish Child Death Review Hub
NHSGGC Child Death Review Governance Group
All contributors to the report
NAME OF CHILD Clinical Portal

Signature of Author
NAME OF AUTHOR
Date of final report

Appendix K
Quality Assurance Checklist for
Child Death Review (CDR) Reports

Patient CHI		**Date Received**		**Quality Assurer**	

All Sections	**Yes**	**No**	**NA**
The report is on the correct template (template to be created)	☐	☐	
The report flows well and is free from spelling and grammatical errors, jargon and abbreviations.	☐	☐	
The report is written in prose and not note form	☐	☐	
Formatting and font are consistent	☐	☐	
Page numbering is present	☐	☐	
Paragraph numbering is correct	☐	☐	
Under 16 year olds are referred to by first name (correct spelling versus Trak) Adults are referred to by their correct formal titles	☐	☐	
There are no tracked changes in the report or timeline	☐	☐	
Cover Page	**Yes**	**No**	**NA**
Patient Information is fully completed and matches Trakcare	☐	☐	
Report author and date of the report are present	☐	☐	
Meeting Review Attendees are recorded (including apologies)	☐	☐	
Documents submitted for Review meeting are recorded	☐	☐	
Section 1: Introduction	**Yes**	**No**	**NA**
Introductory / terms of reference paragraph is included	☐	☐	
Section 2: Family Involvement	**Yes**	**No**	**NA**
This section is fully complete and any questions the family have asked to be answered are detailed here	☐	☐	
Section 3: Background History	**Yes**	**No**	**NA**
The History is adequately detailed and contains relevant health and social dates / milestones / engagement with services.	☐	☐	
Section 4: Detailed Description of Child Death	**Yes**	**No**	**NA**
The description gives a full account of the incident and it is clear what happened	☐	☐	
The description contains facts and not opinions	☐	☐	
A summary of relevant information from the post mortem is included	☐	☐	

The cause of death according to PM is clearly documented	☐	☐	
Section 5: Multi-Agency Service Updates	**Yes**	**No**	**NA**
Check that each agency involved has provided either a written update or verbal update is incorporated into report	☐	☐	
Descriptions correlate with all previously noted timelines	☐	☐	
Section 6: Post Event Family Arrangements / Care Provision	**Yes**	**No**	**NA**
The description provides details on bereavement and pastoral support offered	☐	☐	
The description provides details of CDR Team contacts offered	☐	☐	
The description documents whether a copy of the report has been requested by the family	☐	☐	
Section 7: Learning Points	**Yes**	**No**	**NA**
Are the learning points from the case sufficiently detailed as to be recognisable by the relevant actionee	☐	☐	
Actions required are SMART (***S**pecific, **M**easurable, **A**ttainable, **R**elevant, **T**ime-related*.)	☐	☐	NA
Section 8: Conclusion	**Yes**	**No**	**NA**
Have all five terms of reference been met:	☐	☐	☐
1. To ascribe a final cause of death and of any relevant associated factors	☐	☐	☐
2. To consider the ongoing support needs of the family and/or siblings	☐	☐	☐
3. To consider relevant plans for supporting any potential future pregnancies	☐	☐	☐
4. To consider any points of communication for the family	☐	☐	☐
5. To consider any factors which are potential learning opportunities for NHS Scotland and in particular Greater Glasgow and Clyde in the context of this death event	☐	☐	☐
Section 9: Governance	**Yes**	**No**	**NA**
Has the report been approved by all contributors	☐	☐	☐
Is it clearly documented who should receive a copy of the report (including shared-care health boards)	☐	☐	☐
Sign Off	**Yes**	**No**	**NA**
Quality Assurance review has been approved	☐	☐	
Has the clinical lead author confirmed a final sign off copy post QA	☐	☐	
Has the report been uploaded onto Clinical Portal	☐	☐	
Has the report been uploaded to Scot Gov CDR Hub	☐	☐	

Royal Hospital for Children, Glasgow

Patient Services Department
Royal Hospital for Children
1345 Govan Road
Glasgow
G51 4TF

Appendix L Post Review / Report Letter {remove header prior to sending}

Our Ref: CHI Number
Date: DD Month 2021
Our Tel: 07929 659967
Our Email:

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,

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 Zoom) 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