When a child dies: The Child Death Review Process

A guide for bereaved parents, families, and carers

Supporting parents, families, and carers in Scotland with their Child Death Review

Every child's death is a tragedy for their family and loved ones. We are very sorry your child has died, and it is important to understand as much as we can about what and why this happened.

A Child Death Review (CDR) looks into all aspects of your child's death, any care your child received, and the circumstances leading to their death. It is important to support you in understanding why your child died, and to learn lessons that may help prevent other children or young people dying from similar causes.

New arrangements came into place in Scotland in October 2021 to ensure that the death of every child or young person is reviewed to an agreed minimum standard that respects their rights, as well as the rights of their family and carers.

Reviews take place where any child under the age of 18 dies or following the death of any young person or young adult up to the age of 26, if they were receiving continuing care or aftercare support from the local authority at the time of their death.

It can take several months before a review meeting is held. For some families, being contacted about it might come as a shock or feel upsetting. Our aim is to explain the review process and prepare you with this leaflet.

Key contact

You should be given a key contact to talk through all information regarding your child's death and answer any questions you may have. The key contact can be a healthcare professional, social worker, police officer, bereavement support worker, education representative, or another professional involved in the review of your child's death.

If you have not been given a key contact, ask for one from whoever has spoken to you about your child's death, for example your child's consultant or their nurse if they spent time in hospital. You could ask your local NHS board or local authority if you can speak to a chaplain,

bereavement counsellor, or a member of staff trained in providing bereavement support.

Your key contact may be someone that the family already knows and has met or may be a person that is new to you. Your contact will be able to explain how the review works and answer any questions.

Your key contact should arrange to meet with you before the review meeting. They will attend the meeting on your behalf, and will be your voice at the meeting, asking any questions you may have and ensuring your views are represented. They will provide you with feedback following the meeting.

My key contact is: ----------

Phone: ----------

Email: ----------

The length of time it takes to complete a review will vary, depending on the circumstances of your child's death, and the number of people who may be asked to contribute. You may hear different types of review being referred to, such as: a fatal accident enquiry, significant adverse event review, sudden unexplained death in infancy review, or learning review, among others. Your key contact should keep you updated during the review process and tell you when the findings are expected.

The views of families and carers are central to any review of the death of a child. Your views and feelings, and any questions you may have about your child's care, will be considered by the review team as they look closely at the circumstances of your child's death.

Not every person whose child has died wants to engage with the review process, so do not feel you must. Even if you do not wish to submit questions you can still find out what the review findings were by asking your key contact.

Most child deaths where a child is under 18 are due to health conditions, so the local NHS board often leads the child death review. The review may include staff from a range of different services, such as health professionals, teachers, police officers, ambulance crew, or social workers. In some cases, it may be more appropriate for the review to be led by the local authority. Sometimes, more than one NHS board or local authority will be involved: for example, if your child lived in one area and died in another.

It is really important that wherever possible we learn lessons about your child's care including what worked well and what needs to change and improve.

Since October 2021, the National Hub for Reviewing and Learning from the Deaths of Children and Young People has been working with NHS boards and local authorities in Scotland to gather and analyse information surrounding all deaths of children and young people. The National Hub identifies learning that can be shared across Scotland, with a view to influencing changes nationally and locally, to help reduce avoidable deaths in the future.

The review process differs from an organisation's complaints process. If you have a concern about your child's care and you wish to raise a formal complaint, you should contact your NHS board or local authority as soon as possible. In the first instance, speak to a member of staff.