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Supporting parents, families and carers in Scotland with the child death review process

Produced collaboratively by the National Hub
for Reviewing and Learning from the Deaths of
Children and Young People, third sector partners
and bereaved parents, carers and family members

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We are sorry your child has died.

The death of a child is the most traumatic experience any family can go through. While every family's experience will be different, the initial days, weeks and months following your child's death are likely to be extremely difficult.

This leaflet contains clear information about the review process when a child dies:

- what is happening and why, and
- who to contact for more information and support, should you want it.

You should have a key contact to talk through this information and help answer questions. The key contact can be a:

- healthcare professional
- social worker
- police officer
- bereavement support worker
- education representative or
- another person involved in the review of your child's death.

If you do not have a key contact, ask for one from whomever has spoken to you about your child's death.

My key contact is _____

Phone _____

Email _____

In this booklet, 'child' can mean a baby, child or young person.

Why is my child's death being reviewed?

Every child's death is a tragedy for their family, friends and loved ones. It is important to understand as much as we can about what happened and why your child died. A review of your child's care and circumstances of death aims to help families understand what happened. It allows services to learn any lessons that could prevent other children or young people dying from similar causes.

Reviews should take place following the death of any:

- child under the age of 18
- young person who was receiving [continuing care or aftercare](#)^[1] support from the local authority at the time of their death, up to their 26th birthday.

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Losing a child is like learning to live in a foreign land - nothing makes sense and you have to take your time to understand things. What may seem straightforward to a professional is like talking a foreign language to a bereaved parent.

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¹In Scotland, all children living with foster carers, kinship carers or in residential care on or after their 16th birthday are entitled to remain in the same place with their same carers up until their 21st birthday, or they can request advice, guidance and assistance, or aftercare support from their local authority, up to the age of 26 years.

What can I expect from the review process?

Knowing how and why your child died may help you begin to make sense of their death as you grieve your loss. The review will bring together staff involved in your child's care, who will talk openly about the care your child received. It will look closely at the circumstances of your child's death and will:

- look at your child's health and care records
- consider and answer any questions or concerns you may have
- review guidance and policies to ensure the care your child received was appropriate.

Families do not attend review meetings, but their views are important to the review. Not everyone whose child has died wants to be involved in the review process, so don't feel you have to. Your key contact or a member of the review team will explain the review process. They will address your questions or concerns during the review.

The findings from reviews can vary. Some may show that services need to make changes to the way care is delivered. Others may find that the care given to a child was appropriate and to a high standard.

You can speak with your key contact about how you would prefer to receive the findings from the review. For example this may be in person or by letter. You may also choose not to receive any feedback. You will still be able to ask for this and to ask questions at a later time.

Who might be involved in the review?

Depending on the services involved in your child's life and care, the review team may include staff such as:

- your GP
- health professionals
- teachers
- police officers
- ambulance staff or
- social workers.

You can ask that certain professionals that you consider important attend the meeting. This could be a representative from any other organisation that has supported you.

Someone will be appointed to lead the review. This is usually a senior member of staff, who may or may not have had any involvement in your child's care. You will not be invited to attend the review meeting. Your key contact will make sure your questions or concerns are addressed. They will tell you who is involved in the review and will keep you informed about the review's progress.

How long will the review take and when will I receive the findings?

The length of time it takes to complete a review will vary. It depends on the circumstances of your child's death and the number of people involved. This means it is not possible to predict a specific timeframe.

Reviews can be called different things. The name given to a review often reflects the circumstances of a child's death. For example, a sudden unexplained death in infancy (SUDI) review, or a fatal accident inquiry, among others. They all aim to:

- understand how and why your child died, and
- learn lessons that may help prevent other children or young people dying from similar causes.

Your key contact can tell you more about your child's review and can keep you updated on when the findings are expected.

Where do I direct my concerns or complaints (and what's the difference)?

Concerns

The review will address any questions or concerns you may have about your child's care and their death. You can also speak with your child's lead clinician.

Complaints

You can make a complaint to express your dissatisfaction with any aspect of your child's care. You will receive a formal response. In this case, you should contact your NHS board or local authority.

There is usually a time limit on making complaints. This is because it is better to investigate and resolve any issues as quickly as possible. So you should avoid waiting for the outcome of the review if you have a complaint.

See the Useful Resources at the end of this leaflet more information on making a complaint.

How will my child's review make a difference to others?

It may be very difficult to think about other families as you grieve the loss of your own child. We know that most child deaths are not preventable, but it is important that we learn as much as we can to help us understand where care was good or where it can improve. This may help prevent future deaths of other children dying from similar causes.

The National Hub for Reviewing and Learning from the Deaths of Children and Young People works with NHS boards and local authorities in Scotland. It examines information about the deaths of all children and young people. Your child's information will be treated sensitively and confidentially. The National Hub identifies learning to share across Scotland. It aims to influence changes, and to help reduce preventable deaths.

Find out more about the work of the [National Hub](#) online.

Where can I find further information and support?

When a child dies, families can experience an overwhelming sense of grief and loss. Support can come from family members, friends or faith organisations. Sometimes practical and emotional support comes from a GP or specialist bereavement organisation. See 'Useful resources' for where to start finding help online. Your key contact will tell you about local support services, should you need them right now or later on.

“

[The charity] have always been there to support our family, even when we moved out of Scotland for a period of years. They helped us find support in the locations we moved to and were even willing to send us resources.

”

Useful resources

Bereavement support

The Scottish Government website links to a range of useful resources and organisations that can provide emotional and practical support.

[Support if a child or baby dies](#)

[Bereavement support for children and young people](#)

ataloss.org and your key contact can also tell you about bereavement services in your local area.

Making a complaint

[NHS: feedback, complaints and your rights](#)

[Local government: how to make a complaint](#)

[Police Scotland](#)

Other national organisations

[CELCIS – Centre for excellence for children’s care and protection](#)

[National Hub for Reviewing and Learning from the Deaths of Children and Young People](#)

Local support

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You can read and download this document from our website.

We are happy to consider requests for other languages or formats.

Please contact our **Equality and Diversity Advisor** on **0141 225 6999**

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