CHILD DEATH REVIEWS (CDR) IN DUMFRIES AND GALLOWAY

The development of a service in Dumfries and Galloway as a part of Healthcare Improvement Scotland's National Hub Programme for Reviewing and Learning from the Deaths of Children and Young People from October 2021

WHAT IS CDR ?

- A Child Death Review or CDR was Launched by the Scottish Government on 1st October 2021.
- This, to ensure that the death of every child is reviewed to an agreed minimum standard.

Criteria for CDR:

- All deaths of any live born infant aged 22 weeks gestation or more, child or young person up to aged 18, or up to the age of 26 for those who are accommodated or in care at the time of their death.
- The child must be a Scottish resident.

WHAT ARE THE AIMS OF THE CDR PROCESSES?

- To ensure one quality review of all child deaths who meet the CDR criteria.
- Work in partnership with families to answer outstanding questions.
- Work with multi-agency partners.
- complete a core dataset and where applicable an outcome report.
- Ensure any learning points from the CDR reviews are shared for the purpose of improvement services
- To improve the journey of family and carers

KEY ACTIVITIES AND MILESTONES

2021	• Launched the National Hub child death review process on 1 October 2021
2022	• Built a network of multiagency leads responsible for establishing local system of processes in NHS Dumfries and Galloway • Built local response process for each reported death for 0-18 and 18 –25 • Implemented child death review processes for each reported death in Dumfries and Galloway • Established monthly child death governance meetings with multi-agency partners to ensure quality reviews for each reported child death • Gained approval from Patient Safety Group as an governing body for local child death review group • Development of the local bereavement support leaflet information for the families
2023	• Local Annual Report for Child Death Reviews • Online reporting portal where all child deaths are submitted • Development of multi-agency response pathways for sudden deaths in communities for 16+ child deaths
2024	• Sudden death response pathways for multiagency partners for all child deaths. • Plans for 2025 – CDR bite size engagement sessions for all staff in acute settings.

SERVICE DEVELOPMENT PATHWAY

Focus

- Quality reviews
- Engagement with families
- To deliver change

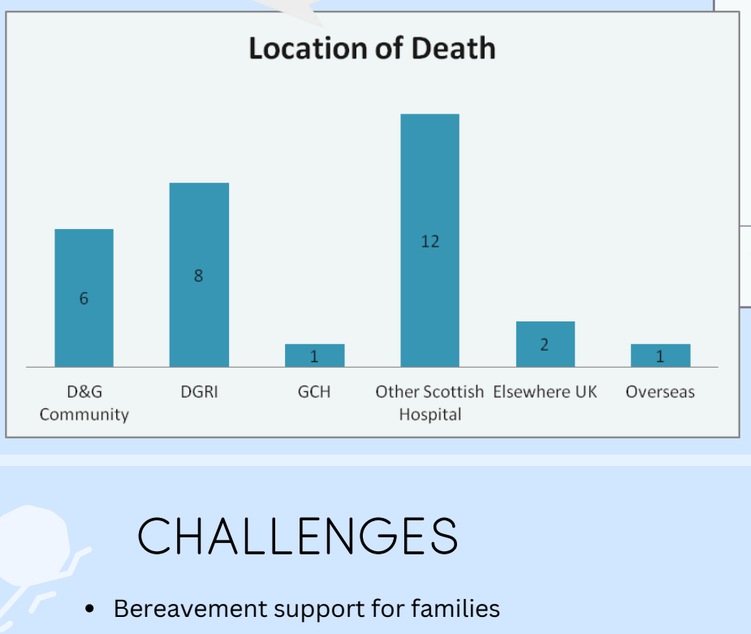
Resources

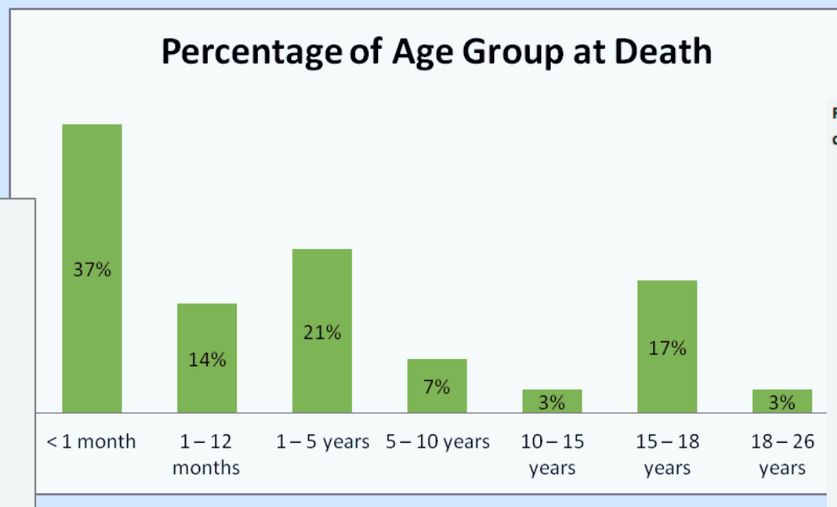
- Paediatric Clinical Lead
- Patient Safety Team support
- Local Bereavement Leaflet
- Multi-agency multi-disciplinary partners

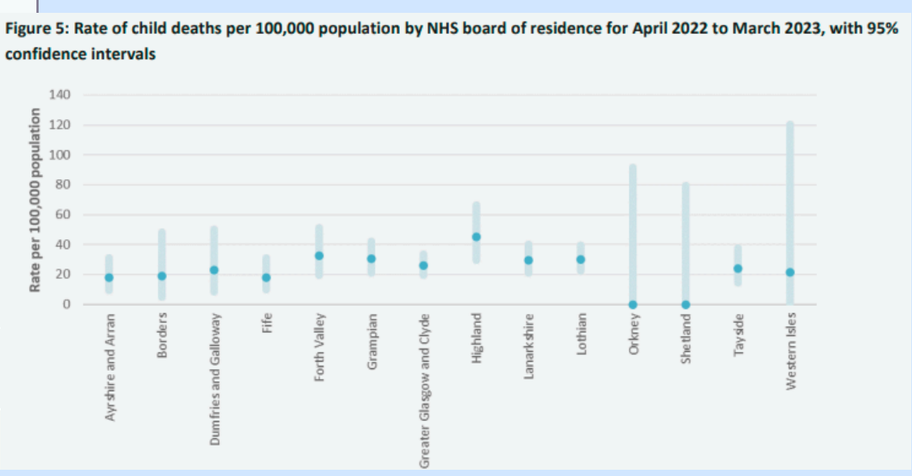
Service design

- Multidisciplinary and multi-agency teams
- Clear pathways
- Peer support

National Level	Design	Advice	Implementation
Scottish Government as initiator	Pathways to all child deaths notifications	CDR Health Boards Scotland	W&C Team
HIS, Care Inspectorate CDR **National Hub**	Multi-agency partnership working	UK National & International Agencies	Patient Safety Team - Adverse Events
Local dissemination **CDR Dumfries and Galloway**	Local CDR Governance Group reporting to PSG	CDR National Hub	Multi-agency partners
	Reporting back to National Hub on all local CDRs	UK-wide CDR programmes	







CHALLENGES

- Bereavement support for families
- Multi-board reviews
- Delays in information gathering
- Increasing awareness of child death reviews
- Resources
  - time to complete work

CURRENT CASELOAD

11 Open reviews

30 Total cases from 1October 2021 to 22 October 2024

TESTIMONIALS

"Thank you for working so hard on bereavement. Your efforts to make the process easier for staff to support families is greatly appreciated. From writing checklists to ensuring we have the best resources for making memories and for taking on such a big project with the pathways and making sure it is being implemented to the best standard".

"Showed compassion to staff who are providing bereavement care to families".

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