Guidance for Notification of All Child Deaths

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Contents

1 Introduction

1.1 The death of any child or young person is a tragic event for families and a key priority at all stages should be to ensure that families can access support and information.

1.2 Scotland has a higher mortality rate for those under the age of 18 years than most other Western European countries. Most child deaths are related to medical conditions or associated with prematurity though just over a quarter of deaths are thought to be preventable. There are approximately 300 deaths per year in Scotland with about a quarter within NHSGGC. In order to support reviewing and learning from deaths the National Hub for Reviewing and Learning from Deaths of Children and Young People has been established.

1.3 This guidance supports the early notification of all child deaths in a timely manner to sensitively communicate with health professionals who may have been involved with the family, ensure early support for staff and families, and provide effective multi-agency communication when this is required.

2. Purpose of Guidance:

2.1 The purpose of this guidance is to clarify the initial requirements of what to do following all child deaths and ensure immediate notification of the death to any professional known to be involved with the child or family.

2.2 It will provide staff with clarity to initiate the Datix process (risk management system) following every child death including issuing of a briefing note and updating IT systems following the death of a child.

2.3 It will address the role of the Public Protection Service (PPS) to collate and analyse health information where there are/are not brothers and sisters of a deceased child and where there may need to be a multi-agency response following the death including rarely when there may be child protection concerns.

2.4 Raise awareness of National Guidance for reviewing child deaths and support information for families. National hub for reviewing and learning from the deaths of children and young people – Healthcare Improvement Scotland

2.5 Finally, it will consider the need to ensure staff have access to appropriate support following the death of any child they have provided care to.

3. Scope:

3.1 In line with National Hub criteria, this guidance relates to all child deaths up to the date of their **18th birthday** and who die within NHSGGC**.** It also includes children who are residents within NHSGGC but who die elsewhere

3.2 The guidance covers live-born babies where a death certificate has been issued. In the event that the birth is not attended by a healthcare professional

initial enquiry may be held to determine whether or not the baby was born alive. This guidance does not include stillbirths.

4. Guidance for Notification of All Child Deaths

a) Incident Reporting by Datix

Following **all child deaths (expected and unexpected),** a datix incident report must be completed. This creates an official 'record of the event' and supports the governance arrangements and reporting arrangements for NHSGGC Child Death Review Team. Incident analysis enables learning from events, supports the development and improvement of services and the identification of learning and education needs. It is important that the incident is reported on Datix timeously, **ideally within 24 hours**. Further details can be added to the incident report at a later date.

Accessing datix incident form to record child's death:-

- From desktop/laptop/tablet click on Microsoft Edge icon
- GGC-Staffnet Hub should be the home page
- Click on 'Datix Quick Link' on right hand side
- Select **"Submit an Incident"** on right hand side
- **'Section 2:Incident/Near Miss details'** of datix incident form (DIF) has specific mandatory field to complete to report whether the incident is related to a child death
- DIF also has a final question in section 2 'Is there a public protection concern?' If the professional believes there may be a child protection concern select 'Child' from drop down options. Staff will also be prompted to indicate whether they require to submit a notification of concern. If no known concerns choose 'No' from drop down options. This can be updated at any stage of the child death review process.
- Or access directly via http://datix.xggc.scot.nhs.uk/datix/live/index.php

b) Health Professional Completing Datix

Expected Child Deaths

When the child's death has been anticipated due to a known health condition this should be completed by a health professional either within a Health and Social Care Partnership (HSCP) or acute services who have been directly supporting the child and family. This should be agreed locally and likely be the responsibility of a number of professionals which could include the following: the Health Visitor (HV), Family Nurse (FN), School Nurse, Team Leader, Service Manager, Medical Consultant, Charge Nurse or Senior Charge Nurse.

Unexpected Child Deaths

The health professional initiating the Datix process does not have to have known the child or young person as some children and young people may not have been receiving any recent direct health intervention and were not

known to services.

All unexpected child deaths should also have a briefing note completed within **24 hours** following submission of the Datix.

All unexpected child deaths must be reported to the Public Protection Service (PPS) on 0141 451 6605. However it should be noted that not all unexpected child deaths will result in child protection processes being instigated.

c) Notifying Public Protection Service

When the Locus of the Death is in the Community

For children there is an expectation that the Children and Families Team Leader, Family Nurse Supervisor (if known to Family Nurse) or Children's Service Manager will inform the Public Protection Service (PPS) by telephone to commence the child death notification process.

The Team Leader, Family Nurse Supervisor, Service Manager or other appropriate health professional will then inform all other relevant HSCP staff including the Child's GP and Specialist Children's Services where relevant and record the death on Datix Incident Reporting Form.

In all circumstances where there has been a child death **(under the age of 16 years**) in the community, the deceased should be transferred to the Emergency Department at Royal Hospital for Children to allow appropriate processes to be followed and pastoral care support provided to families and/or carers. (**Appendix 1**). In such cases the HSCP should complete the datix.

When the Child Death Occurs Within Acute Service / Hospital

In the event of a child death in the hospital setting the doctor or nurse in charge should contact the child's GP and the Public Protection Service to commence the child death notification process.

The Public Protection Nurse Advisor should advise the relevant Team Leader/Family Nurse Supervisor (if known to Family Nurse) in HSCPs and Specialist Children's Services where relevant following discussion with acute staff to ensure they are aware of the child's death.

d) Role of Public Protection Service following Notification of a Child Death (Appendix 2)

Following notification of the child's death a Public Protection Nurse Advisor (PPNA) will:

1. Check with social work if child is known to their service. If known to social work service then details are included in the Child Death Notification Document (**Appendix 3**).

2. Collate and analyse health information to identify any relevant issues which would contribute to Police Scotland / Social Work / Sudden Unexpected Death in Infants (SUDI) enquiries. This will comply with GDPR (2018) and GIRFEC (2014).

3. Inform staff on record management and advice to record details on relevant clinical systems (EMIS, Clinical Portal and Trakcare) and advise that Police Scotland may request access to records for further investigation. The death of a child should be recorded as a significant event in brothers and sisters EMIS records.

4. PPNA should acknowledge that all staff should be offered support via managers after a child or young person has died and provide signposting if required.

5. PPNA will consider the need for an Interagency Referral Discussion (IRD) in relation to the brothers and sisters of the deceased child.

6. PPNA will issue the Child Death Notification form (Appendix 3) which must include the child's age, DOB, CHI number, date and time of death and a brief outline of the circumstances surrounding the death. This information should be shared with the following individuals:-

   - Executive Nurse Director
   - Deputy Nurse Director- Corporate and Community
   - Deputy Nurse Director- Acute Division
   - Lead Paediatrician for Child Protection
   - Chief Nurse & Head of Public Protection Service
   - Public Protection Medical Lead Public Protection Service
   - PPS Lead Nurses - (Child Protection / Adult Support and Protection)
   - Chief Nurse HSCP
   - Head of Children`s Service/ Service Manager / Senior Nurse HSCP
   - Chief Nurse for RHC
   - Director of Midwifery
   - SUDI Lead and Child Death Review Clinical Lead
   - Any other relevant professional identified – for example if child or young person has been receiving care from Specialist Children's Services

7. The PPNA should share information with health professionals in relevant Health Boards for children and young people who die within NHSGGC but reside elsewhere.

   When there is a sudden unexpected death in infancy (SUDI) the SUDI process is followed. The SUDI processes are now part of the National Hub for reviewing and learning from the deaths of children and young people. Sudden unexpected death in infancy programme (SUDI) – Healthcare Improvement Scotland

   The website provides information on guidance for professionals, the process followed after a SUDI and access to support.

5. Multiagency Response to Child Deaths

Following the death of a child there are legal procedures that must be followed. Crown Office and Procurator Fiscal Service (COPFS) has responsibility for investigating sudden, suspicious, accidental and unexplained deaths of children. As such Police Scotland may be requested to investigate a death though this does not mean that they believe a crime has been committed or that there are any child protection concerns. It is therefore important there is robust information sharing to help establish the circumstances of the death and whether any further action will be taken.

a) Interagency Referral Discussion (IRD)

An IRD should be considered if one or more of the following criteria are known:-

- Child open to Social Work and/or on Child Protection Register.
- Child is care experienced or in receipt of through care/aftercare.
- Neglect or abuse identified as contributing factors to death or concerns raised about neglect or abuse prior to death.
- Family and/or other brothers and sisters have been known to Social Work.
- Professional concerns raised by any agency following the death.
- Initial findings from Post Mortem raise potential child protection concerns.

Partner agencies should follow local IRD processes. The original datix incident report should be updated and flagged to **'child protection'**-

Flagging a child protection incident within Datix: –

- In **'category'** section select **'other incidents'**
- In **'sub category'** select '**child protection issue'**

b) Child Death Multidisciplinary Team Meeting

If none of the criteria outlined above are met a Child Death Multidisciplinary Team Meeting (MDT) should be held. The purpose of the Child Death MDT meeting is to help identify, as far as possible: cause of death; relevant professionals involved; ensure adequate support to family and staff and to facilitate relevant information sharing across partner agencies to support Police Scotland with their initial enquiries.

The Public Protection Service will be responsible for initiating a Child Death MDT.

c) National hub for reviewing and learning from the deaths of children and young people

The National Hub aims to ensure that the death of every child in Scotland is subject to a quality review. Wherever possible, a single review of the child's death should be conducted to minimise any associated stress or anxiety of bereaved family members or the staff who cared for or supported the child. It will therefore be important that organisations and relevant partnerships such as the child/public protection committees, consider and agree together the most appropriate approach to follow to minimise any potential duplication or overlap. Guidance has also been developed to cover consideration of parallel or other review processes and investigatory proceedings involving COPFS. (**Appendix 4)**.

6. Potential Child Protection Concerns following postmortem

Rarely, but significantly, the postmortem following the death of a child or young person identifies findings which may raise potential child protection concerns. The lead pathologist will complete form (**Appendix 5**) and share with Police Scotland and the Public Protection Service. (**Appendix 6**). The Public Protection Service will share this with relevant Social Work Department.

As noted, Police Scotland and COPFS both have responsibilities in reviewing and reporting on unexplained deaths in children. However, it is also essential that relevant information or concerns that have been identified at postmortem are shared timeously with health and social work colleagues. This will require an initial or reconvened IRD to discuss findings and any impact on brothers or sisters.

This will facilitate analysis and a consideration of the risks to brothers and sisters including unborn babies in the context of further maternal pregnancies. In such circumstances early discussions should be held with Police Scotland and COPFS to agree parameters of information sharing and satisfactory protection of children.

7. Recording Deaths in Health Records

Consideration should be given to parents potentially having future pregnancies following a child death specifically where there have been child protection or welfare concerns. It is essential that details are recorded within key health records to ensure this information is available to inform risk assessments in further pregnancies for either parent and ensure appropriate support.

When the GP practice receives notification of child death it is appropriate to add read code to maternal/paternal/brother and sister's GP record to reflect the child death. If child protection concerns have been identified this should also be recorded in all GP records.

A significant event should be recorded in the deceased child's EMIS record and all known brother and sister's records. This should be completed by the HV or

FN or relevant Team Leader.

Maternity staff should record the child death within Badgernet maternity record system.
It is important that electronic records are updated timeously to avoid routine appointments being sent out to families following a child death. The Child Health Screening Department are responsible for updating EMIS records to deceased status.

8. Deaths of Children that are Looked After *

Local Authorities have statutory responsibility regarding reporting the deaths of children that are care experienced.

Under regulation 6 of the Looked After Children (Scotland) Regulations 2009, local authorities have a duty to notify Scottish Ministers and the Care Inspectorate of the death of a looked after child and make arrangements to carry out a review. Local authorities are required to submit written notification within 24 hours of any death of a looked after child to Care Inspectorate. Within 28 days, the local authority require to send the Care Inspectorate a detailed report and supporting information. Local authorities should also be aware of their duties to notify the Care Inspectorate without delay of the death of any service user who has died while the care service was being provided, and of the circumstances of the death, including a looked after child. This is in regulation 21 of the Regulation of Care (Requirements as to Care Services) (Scotland) Regulations 2002, S.S.I. 2002/114.

More information can be found on the Care Inspectorate website. Deaths of Looked After Children (careinspectorate.com)

*This guidance reflects the legal definition Looked After but acknowledges the importance of The Promise

9. Staff Support

Managers and those in leadership roles should ensure that health staff involved with a child who has died have adequate support. Consideration should be given to arranging a debriefing with staff to include how staff access support.

Examples of support for staff include the following:-

- Counselling services are available to all NHSGGC employees within the Occupational Health Department. Occupational Health - NHSGGC

- Child Bereavement UK have been commissioned by NHS GGC and funded by the Glasgow Children's Hospital Charity to provide a child bereavement support service across the Health Board. This includes staff support. They provide pre and post bereavement support to families who either live within NHSGGC or where their child attended the Children's Hospital for treatment.

Any family falling out with this criteria but seeking support will be signposted to a service appropriate to their needs and geographical area.

- https://www.nhsggc.scot/staff-recruitment/hrconnect/occupational-health/peer-support-network/
- https://wellbeinghub.scot
- https://www.nhsggc.scot/hospitals-services/services-a-to-z/spiritual-care-and-chaplaincy-service/

Appendix 1

Scottish Ambulance Service
Taking Care to the Patient

NHS SCOTLAND

NATIONAL CLINICAL BULLETIN 011/2022-23

Confirmation of Child Death in the Community

Situation

Following recent audits, SUDI simulation and the annual review of this document, we have identified the need to re-circulate this document as a reminder for all clinical colleagues.

Background

Although rare, the death of a child is one of the most emotionally traumatic challenging events for anyone to encounter. Following the confirmation of death (COD) of a child or young person and in the absence of any suspicious circumstances, the deceased should be transferred to the same hospital destination, as they would have been, if they were being resuscitated. This is to allow early implementation of the sudden & unexpected death in infancy (SUDI) / sudden unexpected death in infancy, child or adolescent (SUDICA) process and to provide pastoral support to the families and carers.

Assessment

On occasions, there has been some confusion between the Scottish Ambulance Service, NHS Health board Emergency & Paediatric Departments as well as Police Scotland, in relation to organisational roles and responsibilities following the COD of a child or young person in the community. I am liaising directly with regional health boards and Police Scotland with the aim of improving the way in which we all deal with these extremely difficult cases.

Recommendation

Please could colleagues re-familiarise themselves with the JRCALC guideline “Death of a Child” as well as the SUDI Scotland tool kit - https://www.sudiscotland.org.uk/ (developed by Health Improvement Scotland), in particular the section entitled professional guidance. Please ensure you contact the receiving unit prior to leaving scene, to allow them to prepare an area suitable for the deceased and SUDI /SUDICA process. Emergency driving is not required.

Should you require any additional advice regarding procedure at scene following of the COD of a child or young person, please contact the duty Clinical Team Leader or the Clinician on call via the ACC. As I said earlier, these can be deeply distressing incidents so please also reach out to your line manager, colleagues, or the Clinical Team leader to talk to them. There are a range of ways in which we can support you.

Should you have any further question, please email me – davidlee.bywater@nhs.scot

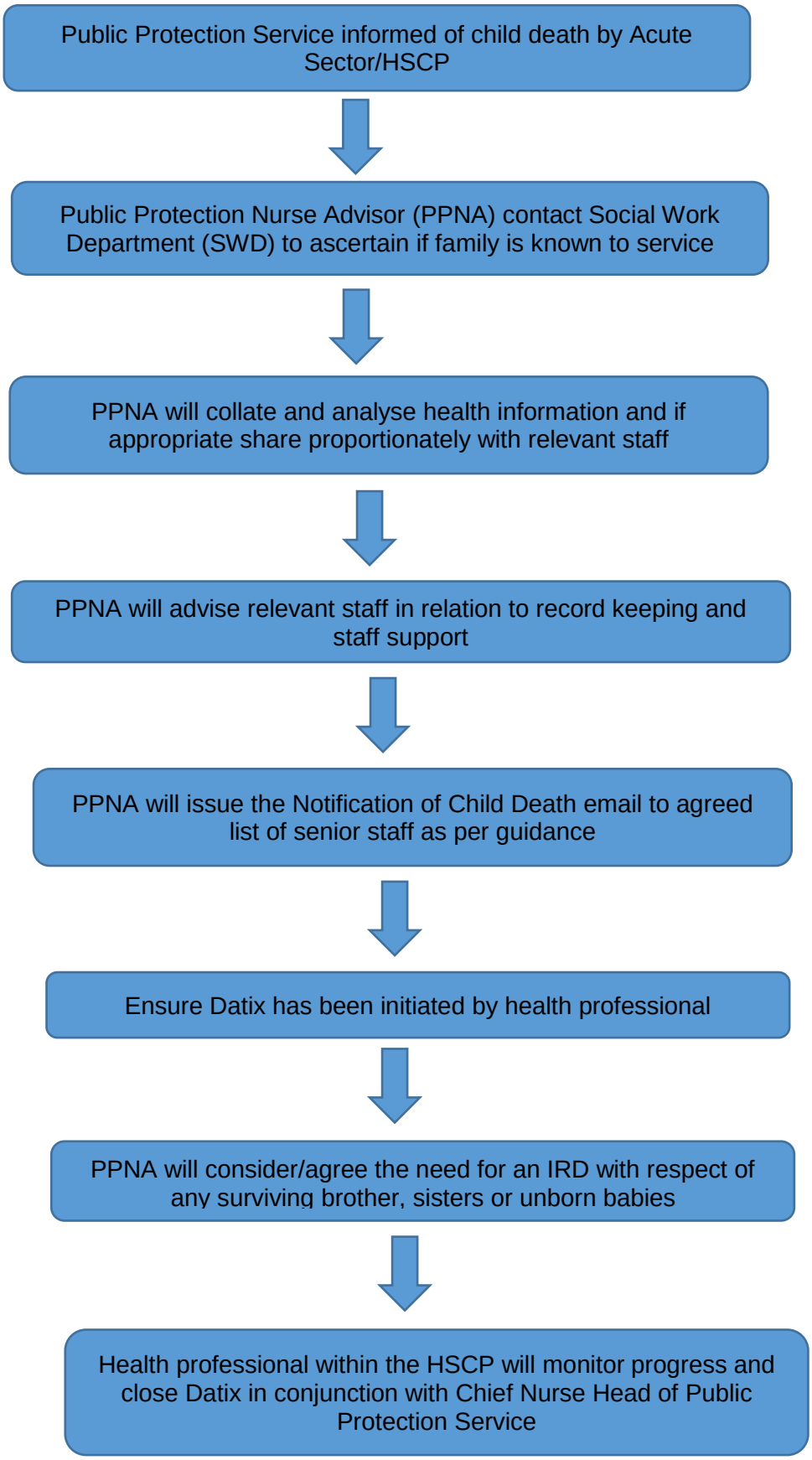
Dave Bywater

Lead Consultant Paramedic

06/09/2022

Appendix 2

Flowchart for notification of unexpected child deaths



Appendix 3

Public Protection Service Child Death Notification

NHSGGC PPS Notification of Child Death

Child's Name:	
Child's DOB/CHI:	
Area of residence:	
Locus of death:	
Date of death:	
Are the family known to Social Work Department?	
Has a Datix been submitted?	
Datix number	
History	
Completed by PPNA:	
Date:	

Please send to the following:

Executive Director of Nursing	☐
Deputy Nurse Director – Acute Division	☐
Deputy Nurse Director – Corporate & Community	☐
Lead Paediatrician for Child Protection	☐
Chief Nurse & Head of Public Protection Service	☐
Lead Nurse for Public Protection Service – Child & Adult	☐
Public Protection Medical Lead	☐
Chief Nurse, Royal Hospital for Children	☐
Chief Nurse HSCP	☐
Head of Children's Service/Senior Nurse/Service Manager	☐
Director of Midwifery	☐
Any other relevant professional i.e. CAMHS, SCS	☐
Lead SUDI Paediatrician & Business manager	☐
PPS generic inbox: ggc.cpadmin@nhs.scot	☐
Child Death Review Team generic inbox: ggc.cdr@ggc.scot.nhs.uk	☐

Please note additional/further details can be obtained by contacting the Public Protection Nurse Advisor on 0141 451 6605

Appendix 4

National hub for reviewing and learning from the deaths of children and young people

Consideration of parallel or other review processes and investigatory proceedings

1. The National Hub aims to ensure that the death of every child in Scotland is subject to a quality review. Within and across NHS boards, local authorities and partnerships, various processes are already in place to review child deaths, with each having a distinct purpose (see National Guidance Appendix 1). In some cases, reviews will be subject to separate statutory guidance, with prescribed timescales and reporting channels to adhere to. Most child death reviews will align to one of these existing review processes; however, there may be times when the circumstances of a child's death may merit consideration of more than one type of review. Wherever possible, a **single review** of the child's death should be conducted to minimise any associated stress or anxiety of bereaved family members or the staff who cared for or supported the child. It will therefore be important that organisations and relevant partnerships such as the child/public protection committees, consider and agree together the most appropriate approach to follow to minimise any potential duplication or overlap. This may require consideration of a 'blended' approach to a review whereby those with a legitimate interest in differing review processes work together to plan their approach, optimise and share learning in real time. Consideration should also be given to which organisation/partnership should complete the core review dataset.

2. While no one process is inherently more important than others, and therefore expected to automatically take precedence, where there are ongoing criminal proceedings or a Fatal Accident Inquiry (FAI) in contemplation, the Crown Office and Procurator Fiscal Service (COPFS) will always have primacy. In these cases, to establish what status your review should have relative to other formal investigations, early and ongoing dialogue must take place with Police Scotland, COPFS or others to determine how far and how fast a review process can proceed. This should ensure that parallel processes are pre-planned and that any changes in status of a child's death are shared. Issues to consider should include:

    - how to link processes
    - how to avoid witness contamination
    - how to avoid duplicate information being collected

3. Where a case is subject to police investigation or court proceedings, these should not inhibit the setting up of a review nor delay immediate remedial action being taken to improve services. It is important that the purpose of the review process, which is to support professional and organisational learning, is understood and remains the focus.

4. National guidance to support Child Protection Committees and Adult Protection Committees undertaking a learning review[1] [2] provides helpful direction for those involved in reviews when parallel processes may be necessary. Both sets of guidance set out key principles that will apply to all circumstances where there are ongoing criminal proceedings or the likelihood of a FAI. A national protocol for the Police Service of Scotland, COPFS and Child Protection Committees (included as Appendix 2 within the national guidance) provides a framework for conducting learning reviews when criminal prosecutions, FAIs or investigations with a view that such proceedings are running in parallel; and for the sharing and exchange of relevant information generated by each process.

5. Once a decision has been made to hold a child death review, communication can be made with COPFS through the Scottish Fatalities Investigation Units (SFIU) in the East, West or North of Scotland. The chair of the review (or named designate) should be the single point of contact for all communication with SFIU.

SFIUWest@copfs.gov.uk
G Division – Glasgow
U Division – Ayrshire
Q Division – Lanarkshire
L, K and V Division – Argyll & Clyde, Dumfries and Galloway

SFIUEast@copfs.gov.uk
E Division - Edinburgh
C Division - Forth Valley
P Division - Fife
J Division - Lothian
J Division - Borders

SFIUNorth@copfs.gov.uk
A Division – Grampian, Aberdeen, Aberdeenshire and Moray
N Division – Highland and Islands
D Division – Tayside (Perthshire, Angus and Dundee areas)

[1] Scottish Government 2021. National Guidance for Child Protection Committees undertaking a Learning Review
[2] Scottish Government 2022. National Guidance for Adult Protection Committees undertaking learning reviews.

6. The role of the Crown Office and Procurator Fiscal Service (COPFS)

As the head of the systems of criminal prosecution and investigation of deaths in Scotland, the Lord Advocate has responsibility for the investigation of all sudden, suspicious and unexplained deaths. This includes the sudden, suspicious and unexplained deaths of children. The purpose of the investigation of a child death is to eliminate the risk of undetected homicide, to identify preventable dangers to life and to the health and safety of children, to allay public anxiety, to restore public confidence, to assist in the maintenance of accurate statistics and to secure and preserve evidence. A child death investigation may result in a prosecution and/ or a Fatal Accident Inquiry in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc (Sc) Act 2016, although not every investigation will result in any court proceedings.

A Fatal Accident Inquiry (FAI) is a type of court hearing in Scotland held in public which enquires into the circumstances of a death. It is presided over by a Sheriff in the Sheriff Court. It is mandatory if the death is as a result of an accident whilst at work or if the death happened whilst in legal custody. FAIs can also be held at the discretion of the Lord Advocate where the circumstances give rise to serious public concern.

The form of the investigation will vary on a case-by-case basis. All investigations require to be independent, effective, reasonably prompt, open to a sufficient element of public scrutiny and one in which the next- of- kin are involved to an appropriate extent. COPFS must consider that every child has the right to life and, to the maximum extent possible, the survival and development of the child should be ensured. Some of the significant factors that COPFS take into account in child deaths investigations are:

- whether there are steps that could reasonably have been taken, and had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided; and
- any defects in any system of working which contributed to the death or any accident resulting in the death.

It is also important for COPFS to have information on any remedial action that has been taken in response to the death and any action plan arising. A robust, timely review of any death will assist in informing COPFS when deciding to make representations to the Lord Advocate as to whether a discretionary FAI should be considered. COPFS may, in certain circumstances, instruct independent experts to review the case overall and consider any review and action plan.

7. Healthcare Improvement Scotland has agreed with COPFS to share the learning points from particular reviews into deaths more widely across NHS Scotland, in order to facilitate national learning and improvement. This process can be of considerable assistance where, for example, an NHS Significant Adverse Event Review (SAER) or Crown-instructed expert report, identifies systemic failures in systems or processes.

By sharing details of those failings as well as any changes to processes by way of a Learning Summary, COPFS can be reassured that that learning has been made known to all the NHS boards in Scotland rather than just the one where the death occurred. In previous cases, this has allowed COPFS to provide confirmation to Crown Counsel (senior legal advocates acting for the Crown) that the changes intended to prevent future similar deaths have been disseminated throughout Scotland and to recommend that no discretionary FAI is required to be instructed to highlight those issues as a result.

8. If COPFS have any cases where the publication of a Learning Summary may be suitable, they are to email his.adverseevents@nhs.scot with brief details of the circumstances. HIS will then discuss with COPFS whether a Summary would be appropriate and, if so, request further information to enable a Summary to be drafted.

The importance, therefore, of a review which thoroughly examines the circumstances surrounding the death and identifies any lessons to be learned to prevent similar deaths could obviate the need for a Fatal Accident Inquiry at a later date. The focus of these reviews is entirely on learning and neither the review nor a FAI seeks to apportion blame to any individual.

Due to the review potentially having a bearing on whether a FAI is held (at the Lord Advocate's discretion) and to maintain that degree of independence, COPFS would not be involved directly in review meetings due to the potential conflict should the death result in a prosecution and/or a Fatal Accident Inquiry.

As reassurance, however, COPFS ask a Victim Information and Advice Officer (VIA) Officer to engage with nearest bereaved relatives of deceased children usually a few weeks after death to explain their role in investigating the death, possible outcomes and thereafter keep families advised of progress every 6 weeks, if they so wish. These VIA Officers can be contacted by those involved in reviews using the same email addresses above.

Once the review is shared with SFIU, it allows for such things as instruction of an expert view in respect of matters which may inform the need for a FAI. The objective of a Fatal Accident Inquiry can be found under s26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Sc) Act 2016 (Appendix 1).

Acknowledgements

This guidance was informed by:

- National Guidance for child protection committees undertaking learning reviews (2021)
- National Guidance for adult protection committees undertaking learning reviews (2022)
- National Hub Guidance – when a child or young person dies (2021)

Appendix 1: s26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Sc) Act 2016.

Section (1) As soon as possible after the conclusion of the evidence and submissions in an inquiry, the sheriff must make a determination setting out—

(a) in relation to the death to which the inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and

(b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers appropriate.

(2) The circumstances referred to in subsection (1)(a) are—

(a) when and where the death occurred,

(b) when and where any accident resulting in the death occurred,

(c) the cause or causes of the death,

(d) the cause or causes of any accident resulting in the death,

(e) any precautions which—

(i) could reasonably have been taken, and

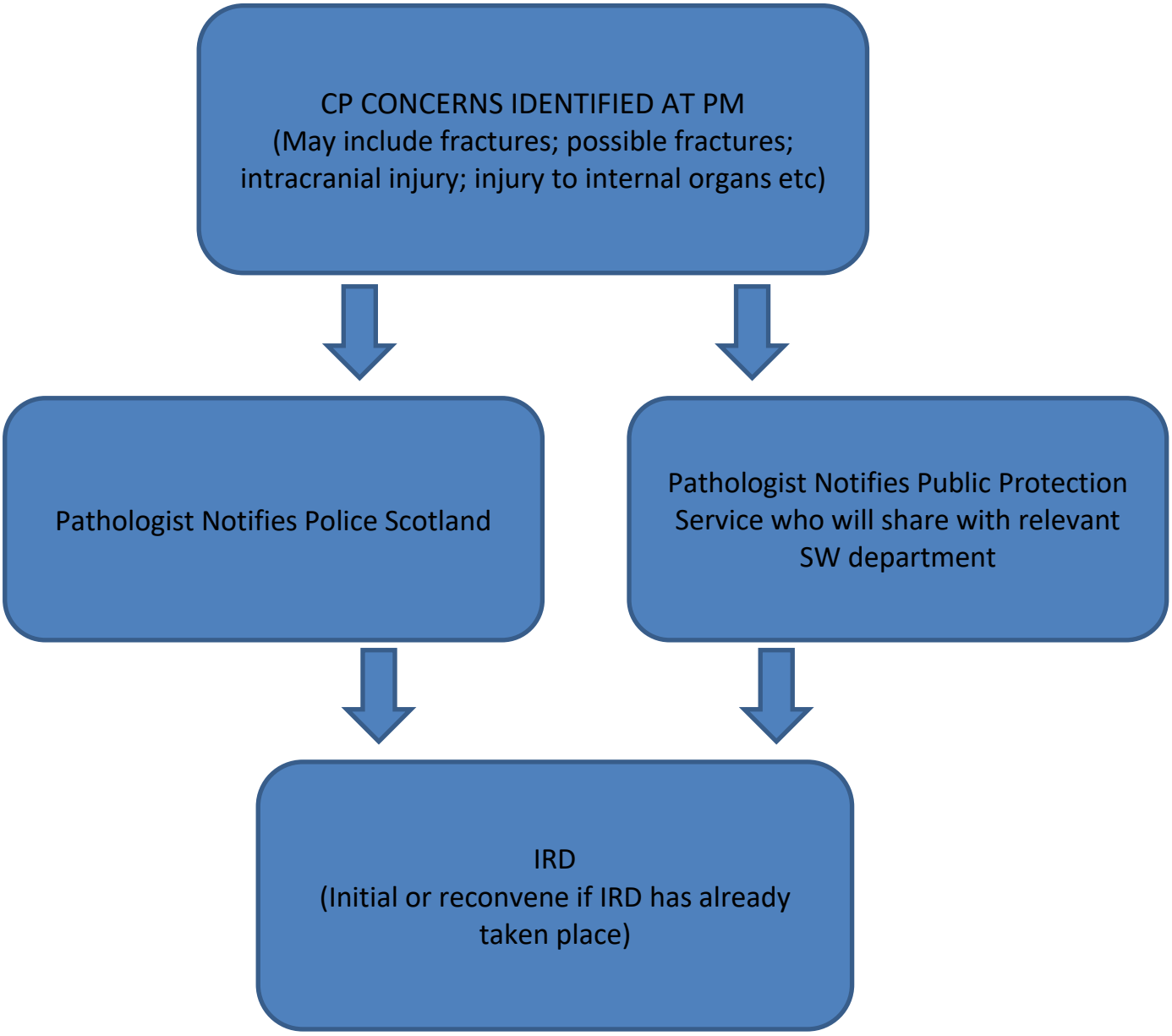
(ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided,

(f) any defects in any system of working which contributed to the death or any accident resulting in the death,

(g) any other facts which are relevant to the circumstances of the death]

Appendix 6

PROCESS FOR NOTIFICATION OF CHILD PROTECTION ISSUES ARISING FROM POSTMORTEM EXAMINATION



Pathologist may need to discuss with COPFS re: release of preliminary information to Police & PPS

Appendix 6

Procurator Fiscal post-mortems - Summary Communication Form

Name of deceased:	
Post-mortem number:	Date of post-mortem:
Pathologist(s): DP	Category: A
Given History:	
Radiology Performed: Yes Radiology reviewed by Pathologist: Radiology Reported:	
Gross Findings:	
Internal Findings:	
Retained Organs: None	

Given Cause of Death (Provisional):

Pathologist's concerns:

Pathologist recommend reporting to Child Protection: YES/NO (please circle)

Other information: Please email images to louise.king5@nhs.scot

COPFS agreement for Pathologist to discuss case with, and distribute report to, relevant medical professionals: YES/NO (please circle)

_____
COPFS Representative (initials)

Discussed with _____ on _____

_____
Pathologist's signature