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| NHS Greater Glasgow and Clyde | Paper No. 25/125 |
| Meeting: | NHSGGC Board Meeting |
| Meeting Date: | 30 October 2025 |
| Title: | FAI Updates |
| Sponsoring Director: | Dr Scott Davidson, Executive Medical Director Jamie Redfern, Director Women & Children's Services Elaine Vanhagen, Director of Corporate Services and Governance |
| Report Author: | Iain Paterson, Corporate Services Manager |

1. Purpose

The purpose of the attached paper is to:

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- a) Acknowledge the findings and recommendations of the FAIs into the deaths of Sonny Campbell and Cailyn Newlands, published 17 September 2025, and the death of Sophia Smith, published 14 October 2025.
- b) Provide re-assurance to the families and those affected on the actions that are being implemented by NHSGGC.

As a Board, we would like to extend our condolences to the families of Sophia, Sonny and Cailyn.

2. Executive Summary

The paper can be summarised as follows:

The FAI Determinations were as follows:

Sonny Campbell

- There are no precautions which could reasonably have been taken that might realistically resulted in Sonny's death being avoided.

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- There were no defects in any system of working which contributed to Sonny's death.
- The Sheriff, having considered the information presented at the Inquiry, made no recommendations.

Cailyn Newlands

- There were no defects in any system of working which contributed to Cailyn's death.
- The Sheriff, having considered the information presented at the Inquiry, made no recommendations.
- However, a precaution which could reasonably have been taken and had it been taken, might realistically have resulted in Cailyn's death being avoided was to have admitted Cailyn to the Clinical Decision Unit on 5 December 2016 for further observation.

Sophia Smith

- There are no precautions which could reasonably have been taken that might realistically resulted in Sophia's death being avoided.
- There were no defects in any system of working which contributed to Sonny's death.
- The infection which contributed to Sophia's death was not related to the built hospital environment and was not associated with the new build hospital at Queen Elizabeth University Hospital campus, Glasgow.
- The Sheriff, having considered the information presented at the Inquiry, made two recommendations:

1. *Weekly screening of vulnerable neonates in intensive care is a useful early warning of Staphylococcus aureus colonisation. This can inform clinical decisions with regard to possible infection and antibiotic therapy. NHSGGC should review the existing protocol in order to ensure that it is properly complied with at all times. Other Health Boards should consider adopting a similar screening process.*
2. *Public Health Scotland should disseminate information on; (a) the risks associated with PVL-MSSA; (b) the difficulties of diagnosis; (c) the advantages of early antibiotic and anti-toxin therapy, and; (d) the learning described by Dr Jonathan Coutts in his evidence, to other neonatal clinical teams throughout Scotland.*

3. Recommendations

The NHS Board is asked to consider the following recommendations:

NHSGGC fully acknowledges the finding in relation to the death of Cailyn Newlands and there is now a process for escalation of returning patients. Many of these would now be streamed directly to CDU. Increased collaboration between CDU and ED teams has also improved with regular face-to-face huddles throughout shifts. Additionally, there is now an increased senior medical presence in both departments, ensuring greater supervision and availability for junior doctors.

NHSGGC also fully accepts the recommendations from the Sophia Smith FAI. An existing action to review the operating procedure for neonatal microbiology surveillance, taking account of Health Protection Scotland's evidence-based screening guidance, was agreed ahead of the FAI, and the Board is advised that this will be completed before the end of 2025.

In addition, NHSGGC will fully engage with Public Health Scotland in its awareness-raising of PVL-MSSA across Scotland.

4. Response Required

This paper is presented for awareness.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

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| • Better Health | <u>Positive</u> impact |
| • Better Care | <u>Positive</u> impact |
| • Better Value | <u>Neutral</u> impact |
| • Better Workplace | <u>Positive</u> impact |
| • Equality & Diversity | <u>Positive</u> impact |
| • Environment | <u>Positive</u> impact |

6. Engagement & Communications

The issues addressed in these papers were subject to the following engagement and communications activity: The responses above have been developed by the Director of Women & Children's Services, Medical Director, Clinical Director and Consultant Neonatologist.

7. Governance Route

N/A

8. Date Prepared & Issued

Prepared on: 16 October 2025

Issued on: 22 October 2025

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| NHS Greater Glasgow and Clyde | Paper No. 25/125 |
| Meeting: | NHSGGC Board Meeting |
| Meeting Date: | 30 October 2025 |
| Title: | Briefing on Fatal Accident Inquiry (FAI) into the deaths of Sonny Campbell and Cailyn Newlands |
| Sponsoring Director: | Scott Davidson, Executive Medical Director Jamie Redfern, Director, Women & Children's Services |
| Report Author: | Iain Paterson, Corporate Services Manager (Compliance) |

1. Introduction

The purpose of the attached paper is to provide assurance to the Board on the learning and actions that are taking place in relation to the FAI Determinations into the deaths of Sonny Campbell and Cailyn Newlands, published 17 September 2025.

The conjoined FAI was heard by Sheriff Brian Cameron in March 2025 at Glasgow Sheriff Court. Upon publication of the determination, a Press Briefing was prepared, through which our Depute Nurse Director extended our heartfelt condolences to the families.

As a Board, we would like to once again extend our condolences to the families of both Sonny and Cailyn.

2. Background

Sonny Campbell sadly died at 1245 hours on 6 December 2016 within the Emergency Department (resuscitation unit) of the Royal Hospital for Children at the Queen Elizabeth University Hospital, Glasgow. The cause of Sonny's death was acute haemorrhagic leucoencephalitis ("AHLE").

Cailyn Newlands sadly died at 2042 hours on 6 December 2016 within the Emergency Department of the Royal Hospital for Children at the Queen Elizabeth University Hospital, Glasgow. The cause of Cailyn's death was Streptococcus Pneumoniae Bronchopneumonia.

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The infants were treated by different doctors and did not encounter one another at the RHC.

The conjoined FAI was called to examine:

- Whether the absence of clear guidance in relation to dealing with patients who had attended at the Royal Hospital for Children on multiple occasions suffering from the same or similar illness within a short timeframe affected the assessments of Cailyn Newlands.
- Whether there was an appreciation for the concern and anxiety shown by Ms Anderson and Mr Newlands in relation to Cailyn Newlands and whether this should have warranted further investigations at an earlier stage. It requires to be determined whether this risk factor was given sufficient consideration to merit a more robust response.
- Whether in both cases Cailyn Newlands and Sonny Campbell should have been reviewed by a Senior Doctor or Consultant.
- Whether further investigations, for example, in the form of a blood test, should have been undertaken in relation to both children.
- In relation to Sonny Campbell, whether there was full recognition of the particular clinical features he presented with, with consideration being given to whether there was adequate training on recognising '*red flags*' in Sonny Campbell's presentation.
- The assessments/working diagnosis of Cailyn Newlands and Sonny Campbell to determine whether there is a training need for Doctors involved in conducting such assessments.
- The nature of the advice and interaction of more inexperienced doctors with those who are more experienced in a busy acute setting, in the context of whether there are appropriate advice and communication channels.
- The nature of the worsening advice given to families, what it consisted of and whether it could have been understood and followed by the average, non-medically trained member of the public.
- The issue of contemporaneous record keeping and the recording of discussions between medical professionals and between the parents of patients and medical professionals.

3. Board Assessment

Significant Adverse Event Reviews (SAERs), were undertaken in response to both fatalities during 2018. In Sonny's case, the SAER identified issues which did not contribute to the event.

There were 4 recommendations in this SAER. As of October 2025, all of these recommendations have been implemented.

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- A more structured “safety netting” process should be developed that gives guidance to staff and families on how and when to re-attend. Consideration should be given to a written information leaflet that can be personalised for individual patients. The impact of this on re-attendance rates should be prospectively audited along with parental/patient feedback on their understanding of the information.
- Steps must be taken to facilitate contemporaneous completion of all medical and nursing notes. Shift timings and the arrangements for the end of shifts should be looked at, as well as the layout of the “ED cards” used as a record of attendance which should have an area for rough note taking which can be retained for future scrutiny.
- The ED paperwork, processes and guidelines should be reviewed to ensure that they are conducive to a structured assessment of the feverish child. The current assessment process involves an initial triage, Early Warning Scoring, Sepsis 6 assessment and the RHCG/NICE guidance. All of these cover similar areas but using differing terminology, consideration should be given to a harmonised approach that better integrates these elements.
- GG&C Management should meet with the Procurator Fiscal and develop a joint approach to any future cases where there is a fiscal interest that provides better support and information for the family pending conclusion of an SCI.

In Cailyn’s case, the SAER identified five issues which did not contribute to the event. The five recommendations are listed below and as of October 2025, have been implemented.

- Review systems for triage, PEWS scoring, sepsis 6 and NICE guidance on management of febrile illnesses in the under fives and consider development of a more cohesive structured approach.
- Review arrangements for providing support and oversight of junior medical staff when the duty ED consultant is attending to another patient.
- Consider development of a structured worsening advice/safety netting process, including consideration of giving written information for those being discharged with a febrile illness and review of the booking in process when re-attending for the same illness
- Undertake an audit/review of the number of patients re-attending with febrile illnesses to gauge the frequency that this occurs with a view to reviewing the current policy for review of repeat attenders.
- Review training and guidance for reception staff to ensure that they are able to respond appropriately when severely ill patients present to them.

4. FAI Determination

The FAI Determination was as follows:

Sonny Campbell

- There are no precautions which could reasonably have been taken that might realistically resulted in Sonny's death being avoided.
- There were no defects in any system of working which contributed to Sonny's death.
- The Sheriff, having considered the information presented at the Inquiry, made no recommendations.

Cailyn Newlands

- There were no defects in any system of working which contributed to Cailyn's death.
- The Sheriff, having considered the information presented at the Inquiry, made no recommendations.
- However, a precaution which could reasonably have been taken and had it been taken, might realistically have resulted in Cailyn's death being avoided was to have admitted Cailyn to the Clinical Decision Unit on 5 December 2016 for further observation.

Although the Board is not required to make any formal response to the Court, there is learning for NHSGGC in that the Sheriff has suggested that a reasonable precaution which could reasonably have been taken and had it been taken, might realistically have resulted in Cailyn's death being avoided. This recommendation was to have admitted Cailyn to the Clinical Decision Unit (CDU) on 5 December 2016 for further observation.

NHSGGC fully acknowledges this finding and there is now a process for escalation of returning patients. Many of these patients would now be streamed directly to CDU. Increased collaboration between CDU and ED teams has also improved with regular face-to-face huddles throughout shifts. Additionally, there is now an increased senior medical presence in both departments, ensuring greater supervision and availability for junior doctors.

5. Conclusions

These were tragic cases. NHSGGC is fully committed to learning from them, having implemented all SAER recommendations as well as the Sheriff's finding from the Inquiry.

We remain committed to providing the safest and highest quality care possible, and, as with all Fatal Accident Inquiries that we participate in, we will continue to reflect and learn from every opportunity to do better.

6. Recommendations

The Board is asked to note the Determination from the FAI, noting where action has been, or is now being taken, to learn and improve services.

7. Evaluation

We continue to actively review and evaluate our pathways and decision-making procedures for paediatric ED admissions as well as our workforce plans to ensure the appropriate clinical skills mix is available at all times and is responsive to seasonal variations in activity.

8. Appendices

Appendix One: Link to the FAI Determination document.

[SHERIFFDOM OF SHERIFF COURT](#)

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| NHS Greater Glasgow and Clyde | Paper No. 25/125 |
| Meeting: | NHSGGC Board Meeting |
| Meeting Date: | 30 October 2025 |
| Title: | Briefing on Fatal Accident Inquiry (FAI) into the death Sophia Smith |
| Sponsoring Director/Manager: | Scott Davidson, Executive Medical Director Jamie Redfern, Director, Women & Children's Services Elaine Vanhegan, Director of Corporate Services and Governance |
| Report Author: | Iain Paterson, Corporate Services Manager (Compliance) |

1. Introduction

The purpose of the attached paper is to provide assurance to the Board on the learning and actions that are taking place in relation to the requested briefing for the NHSGGC FAI Determination into the death of Sophia Smith, published 15 October 2025.

The FAI was heard by Sheriff J McDonald in February 2025 at Glasgow Sheriff Court. Upon publication of the determination, a Press Briefing was prepared, through which our Medical Director extended our heartfelt condolences to the family.

As a Board, we would like to once again extend our condolences to the family of Sophia.

2. Background

Sophia Evangeline Smith died at 1748 hours on 11 April 2017 within the neonatal intensive care unit at the Royal Hospital for Children, Glasgow.

The cause of Sophia's death was Pulmonary haemorrhage and Subsequent post mortem examination established that Sophia had an active blood stream infection

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caused by methicillin sensitive *Staphylococcus aureus* producing Panton- Valentine Leucocidin (PVL-MSSA); this played a material role in her decline and death.

The FAI was called to examine:

- the role of PVL-MSSA infection in cause of death
- the source of the PVL-MSSA infection in baby Sophia Smith and Peripherally Inserted Central Catheter (PICC) hygiene processes
- the source of the PVL-MSSA infection in baby Sophia Smith and the built hospital environment
- the procedure for the detection, monitoring and recording of PVL-MSSA and the response to concerns raised by Theresa Smith in the morning of 10th April 2017 about baby Sophia Smith's presentation
- the communication between healthcare staff and Theresa and Matthew Smith, whether the issuing of the death certificate on 13th April 2017 by Dr Jonathan Coutts was premature given the preliminary results of blood sample tests and the pending post mortem, and whether there was any deliberate attempt to withhold information relevant to baby Sophia's death

3. Board Assessment

The circumstances of Sophia's death were reviewed at the monthly Neonatal Governance meeting and at the Perinatal Mortality Review Group. Discussion with the Procurator Fiscal took place ahead of the death certificate being issued.

4. FAI Determination

The FAI Determination was as follows:

- There are no precautions which could reasonably have been taken that might realistically resulted in Sophia's death being avoided.
 - There were no defects in any system of working which contributed to Sophia's death.
 - The infection which contributed to Sophia's death was not related to the built hospital environment and was not associated with the new build hospital at Queen Elizabeth University Hospital campus, Glasgow.
 - The Sheriff, having considered the information presented at the Inquiry, made two recommendations below
1. Weekly screening of vulnerable neonates in intensive care is a useful early warning of *Staphylococcus aureus* colonisation. This can inform clinical decisions with regard to possible infection and antibiotic therapy. NHSGGC should review the existing protocol in order to ensure that it is properly complied with at all times. Other Health Boards should consider adopting a similar screening process.
 2. Public Health Scotland should disseminate information on; (a) the risks associated with PVL-MSSA; (b) the difficulties of diagnosis; (c) the advantages of early antibiotic and

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anti-toxin therapy, and; (d) the learning described by Dr Jonathan Coutts in his evidence, to other neonatal clinical teams throughout Scotland.

NHSGGC fully acknowledges these findings. An existing action to review the operating procedure for neonatal microbiology surveillance, taking account of Health Protection Scotland's evidence-based screening guidance, was agreed ahead of the FAI and the Board is advised that this will be completed before the end of 2025.

In addition, NHSGGC will fully engage with Public Health Scotland in its awareness-raising of PVL-MSSA across Scotland.

Our formal response to the recommendations will be submitted to the Court for publication by December 3 2025.

NHSGGC also notes that the Sherrif made a number of observations in his determination relating to infection control and communication with parents which are also currently being reviewed.

5. Conclusions

This was a tragic case. We remain committed to providing the safest and highest quality care possible, and, as with all Fatal Accident Inquiries that we participate in, we will continue to reflect and learn from every opportunity to do better.

6. Recommendations

The Board is asked to note the Determination from the FAI, noting where action has been, or is now being taken, to learn and improve services.

7. Evaluation

The impact of the revised operating procedures will be monitored at regular intervals, as well as the national awareness-raising of PVL-MSSA.

8. Appendices

Appendix One: Links to the FAI Determination document.

Link to the FAI determination:

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