Pan-Cheshire Local Safeguarding Children Board (LSCB) Guidelines

(Cheshire East, Cheshire West & Chester, Halton and Warrington)

Pan-Cheshire Guidelines for The Management of Sudden Unexpected Death in Infants and Children (SUDIC)*

***(Children: Aged under 18)**

Version 2.1 - July 2015

INQ0013225_0001

1. INTRODUCTION

1.1 All Local Safeguarding Children Boards (LSCBs) are required to have arrangements in place to review the reasons for all child deaths. This is done through the Child Death Overview Panel (CDOP).

1.2 This guidance provides a framework for the investigation and care of families after an unexpected death of an infant or child.

1.3 The guidance details a multi-disciplinary approach that will ensure to achieve:

- Sensitive care and support to all affected by the death.
- Preservation of evidence at the place of death.
- Full documentation of all interventions by paramedical and medical staff, including resuscitation prior to the certification of death.
- The completion of a full medical history by medical staff.
- A full review of all the medical records of the deceased.
- A paediatric pathologist (and if necessary a forensic pathologist) investigating the cause of death.
- A multidisciplinary case discussion.

1.4 This guidance should be used for the sudden and unexpected death of a child under the age of 18 years irrespective of place of death:

- At home or in the community
- In the hospital Emergency Department or in the Ward

1.5 It is essential that every professional involved in a Sudden Unexpected Death in Infants and Children (SUDIC) case must be fully aware of the guidelines and should keep meticulous records.

1.6 The sudden and unexpected death of any person demands the most thorough investigation of the highest standard. A sudden and unexpected death of an infant or a child (SUDIC) is no exception.

1.7 Unexpected death refers to the death of a child that was not anticipated as a significant possibility 24 hours before the death or where there was an unexpected collapse leading to or precipitating events that led to the death. This would also include unexpected death of a child with disabilities and/or chronic medical conditions (see *Working Together to Safeguard Children, 2015)*.

1.8 Factors in the environment, history or examination may give rise to concern about the circumstances surrounding the death. These SUDIC guidelines should be followed where non-accidental injury is suspected to have resulted in the death of a child.

INQ0013225_0003

2.2 Pathway Following the Death of an Infant or Child under 18 years