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

The Management of Sudden Unexpected Death in Infants and Children (SUDIC) 2015

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.

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

Child Death in Hospital/Community SUDDEN AND UNEXPECTED DEATH OF INFANT OR **EXPECTED DEATH** CHILD (SUDIC) Ambulance and Police immediate response. Detailed review of paediatric Assess immediate risks/concerns. Resuscitation if appropriate. history / examination / Police consider appropriate scene security. investigations and Consider needs of siblings and other family members. documentation. Where appropriate, child and carer(s) transferred to hospital with paediatric facilities; resuscitation continued/decision to stop - Hospital staff notify Police - Lead Police investigator Notify relevant professionals attends hospital. including DDCD / CDOP nurse / CDOP coordinator - Form A; Discuss all deaths with Coroner. Detailed paediatric history / examination and investigations; Complete Pan-Cheshire SUDIC documentation; If suspicious circumstances, joint interview of carers with Police and / or 4 hours Children's Social Care (CSC) advisable. Arrange Bereavement support. If not already notified, inform Police/Coroner/CSC/ DDCD/ Inform re Child Death Review CDOP Nurse/CDOP coordinator/GP/HV/ Other Health process and give Information 0 professionals involved including other health organisations leaflet. using Form A - Notification of Child Death. Immediate discussion (by telephone or in person) with Police/CSC regarding any suspicious circumstances/ Form B to be completed by safeguarding concerns and proceed as appropriate. Attend to Consultant Paediatrician and needs of other children and family members; Decide on need sent to Designated Doctor for for joint home visit (usually within 24 hours), need for Serious Child Death (DDCD), CDOP nurse, CDOP co-ordinator. Case Review (SCR). Inform parents/carers regarding Coroner's Post Mortem and child death review process by CDOP; Give information leaflet; Arrange Bereavement support. Local Child Death Review by Health team to identify gaps and Detailed medical report and Form B to be completed by lessons to be learnt. Consultant Paediatrician and sent to Coroner/ Designated Relevant minutes to be sent to 72 hours Doctor for Child Death /CDOP nurse/CDOP co-ordinator. Designated Doctor for Child Death /CDOP nurse. months Rapid Response meeting (Initial multi-disciplinary meeting) for information sharing/planning and consider need for 1 safeguarding strategy (S47) meeting, convened by police and 9 24 minutes recorded; Decide time/need for SCR/interim multidisciplinary case discussion meeting. Consultant Paediatrician to discuss results of Post Mortem (if applicable) findings / Local Child Death Review by Health Team (with Coroner's investigation results / care of Preliminary Post Mortem results, if available); weeks siblings with parents. Further Police and CSC investigation. ∞ Preliminary Post Mortem report and proceedings to be shared with parents by the Police only if agreed with Coroner and if no criminal proceeding are underway. 2 - 6Final Multi-disciplinary Case discussion meeting convened by DDCD/Consultant Paediatrician with final Post

months Mortem report to share cause of death and plan future care and support for the family. Discuss at Child Death Overview Panel. Consider need for Serious Case Review.