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

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.