The SUDI Project

In 2009 The Scottish Government asked the then NHS Quality Improvement Scotland (NHS QIS), now Healthcare Improvement Scotland, to progress a programme of work on the subject of Sudden Unexpected Death in Infancy (SUDI).

It was agreed that NHS QIS should facilitate development of the following:

- A web based toolkit, providing resources to all professionals involved in the investigation of a SUDI.
- SUDI Review multidisciplinary meetings to be co-ordinated timeously after each SUDI.
- The collection of national data to identify any trends and risk factors, which may influence future practice.
- The evaluation of the SUDI Review process and the toolkit.

This programme of work was funded initially for a period of two years. This toolkit was evaluated for its effectiveness in contributing to the investigation of SUDIs and found to be of use to the many multi agency teams involved.

When the toolkit is not applicable

In a very small number of cases the death of an infant may be due to an act of deliberate harm. In these rare instances the investigation may be conducted differently, and the practice suggested in this toolkit may not be appropriate. However, the professional guidance on support of the family and completion of documentation for police acting on behalf of the Procurator Fiscal should still be applicable, and in particular the family may need additional support from the professionals involved. The SUDI review meeting in particular is **not** appropriate if any legal proceedings are to take place or where a child protection investigation has been instigated.

Staff in any SUDI regardless of the outcome of the investigation may need to access support.

Previous SUDI project in Scotland

In 2001, the Scottish Cot Death Trust (SCDT) piloted the concept of local, multidisciplinary case reviews following a SUDI. The data collection period was September 2001 to August 2004 and included all sudden unexpected deaths in infants under two years of age. The pilot study required participation from all health boards and local authorities in Scotland, along with co-operation from the Crown Office and Procurator Fiscal Service.

One hundred and thirty eight cases were identified, of which 80 (58%) were included for multidisciplinary case review.

SUDI Steering Group

NHS QIS held a stakeholder event in March 2009 in which group discussions centred on the four elements of the proposed programme. Three working sub-groups were set up to progress the individual work streams and collectively form the SUDI Steering group. These members contribute to and oversee the design, dissemination and implementation of each of the above elements.

SUDI Toolkit Sub-group

This group have advised and developed this web based toolkit to provide professionals with information and guidance. The toolkit also explains the investigation of SUDIs and each profession’s role in the process. In particular where they enter and exit the process, which professions they interact with, and what information they may be required to give, or ask of others.

SUDI Review Sub-group

The SUDI review meeting is held shortly after the final post-mortem examination report is available, which may be several months after the infant has died. The purpose is to discuss all aspects of the death, including possible causes or contributing factors to see what lessons can be learned and to plan support for the family, in particular support for any future pregnancy.

Data Collection Sub-group

Both in the investigation of a SUDI and for co-ordination of the SUDI review meeting, data are required to be collected and logged onto a database. The dataset required for the information health professionals will gather during the investigation has been identified.

Healthcare Improvement Scotland SUDI Project Team

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SUDI Steering Group Membership

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Julie-Claire Becher, Consultant Neonatologist
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