Child Protection

The following sections will help professionals working in child protection respond appropriately to a SUDI. Other professionals involved may have addressed some of the issues, but you should not assume that they have. The information may also be useful to other professionals interacting with the team through their involvement following a SUDI.

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Interactive timeline and flow chart

The interactive timeline demonstrates the role and responsibility of a child protection advisor in relation to other professionals involved, and in the subsequent SUDI Review meeting. The scenario illustrated in the flow chart highlights some of the key points but does not aim to show everything that may arise in what is a unique circumstance for each case of SUDI.

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View example scenario (flow chart) »

The role of Child Protection

Child protection underpins all investigations following SUDI. **It is standard practice for a child protection team to be contacted in all cases to make them aware of the infant's death**. The degree of involvement of a child protection team will vary for each SUDI, from maintaining a very peripheral role and concluding their part in the investigation as soon as the initial post-mortem findings are known, to providing ongoing support to the family and staff involved, if child protection issues are raised. Child protection teams include professionals from health care, social work and police.

Child protection staff collaborate with health care professionals, social workers and police to:

1. Initiate and maintain good communication between all agencies involved to ensure clarity of roles.

2. Gather relevant background information.

3. Provide support to primary care colleagues regarding access to medical notes, interviews with members of the police etc.

4. Support the management of a SUDI until post-mortem findings are known.

5. Advise as well as develop policies and practice in child protection.

6. Ensure that the bereaved family understands that child protection involvement **is standard practice in all SUDIs**.

7. Provide the necessary support packages available for the family should they be required.

Child Protection team involvement

1. The child protection team in the hospital is notified by Emergency Department staff when a SUDI occurs.

2. There is interaction with relevant hospital and primary care colleagues, police and social work, as appropriate and an agreement on who makes contact with the following:

- lead paediatrician for the area
- clinical director for children's services

- executive director with responsibility for child protection
- nurse consultant for vulnerable children
- designated doctor for vulnerable children
- the Child Health Commissioner
- chief nurse for the area
- family health visitor for pre-school children.

3. The advisor involved with the case will assess and decide on the level of engagement with maternity and child health services, background history including any previous child protection concerns.

4. The team will remain involved with the case until the outcome of the post-mortem examination is known.

5. The parents/family are informed by Emergency Department staff or a paediatrician it is **standard practice that initial information gathered regarding the circumstances of the death will be shared with the local child protection team.**

6. The parents/family should be reassured that this **does not imply** suspicion or criticism of their care of the deceased infant.

Staff support

The professionals involved may require support. Some professionals may have prolonged involvement in the investigative process and will have no experience of SUDI. This toolkit provides information on staff support.

Steps and timelines around the investigation of SUDI

Each case has unique circumstances which require investigation so there is never an absolute timeline to follow. The following steps should occur:

1. The police will provide the Procurator Fiscal with a Sudden Death report the next lawful day (Monday if the death occurs over the weekend).

2. Original medical records will be requested by the police on behalf of the Procurator Fiscal, and given to the pathologist prior to the post-mortem examination.

3. A post-mortem examination will be requested and normally take place within 48 hours.

4. The paediatrician following up the case will offer to meet with the parents after 1-2 weeks to discuss the process to date and offer ensure appropriate support is available for the family.

5. The final post-mortem examination report can take several months as further examinations of samples will need to be concluded.

6. The Procurator Fiscal will confirm with Healthcare Improvement Scotland that it is appropriate for the SUDI Review meeting to take place once the post-mortem examination report is available, assuming there is no suspicion of criminality. Healthcare Improvement Scotland will liaise with SUDI paediatrician for the NHS Board.

The SUDI Review

The SUDI Review is a multidisciplinary meeting at which the case is discussed. The 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 during and after any future pregnancies.

Participants may include:

- paediatrician
- pathologist
- general practitioner
- community health visitor
- community midwife

- social worker.

The meeting will be held at a suitably convenient time and place for all involved. The SUDI Review meeting will not take place if there is any suspicion of criminality or if a Significant Case Review has to take place through Child Protection.