Paediatrics (General)

The following sections will help paediatricians to be able to 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 paediatrician through their involvement following a SUDI.

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Roles are often shared between Emergency Department staff and paediatricians if on site. The SUDI paediatrician for the health board should take overall responsibility to ensure local awareness of this guidance. Local variations on who takes individual responsibility for the actions should not prevent use of the guidance being implemented.

Interactive timeline and flow chart

The interactive timeline demonstrates the role and responsibility of a paediatrician 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.

View example scenario (flow chart) »

When a SUDI occurs

1. You may be notified by the Emergency Department in advance if they are aware that an infant is being brought in, as per the Emergency Department guidance for SUDI.

2. Clarify with Emergency Department medical staff who is responsible for supervising resuscitation, and who is responsible for supporting parents during the resuscitation, whether you will take over responsibility for the support of the parents. In some Emergency Departments the staff there will have the initial contact with the family.

3. Support the family in the resuscitation room (if they wish to be present), and explain the resuscitation process throughout.

4. Once death has been pronounced (paediatrician may pronounce) examine the infant and record notes using the infant body map.

Initial parent support

(Agree with Emergency Department staff who will undertake these tasks)

1. See the parents as soon as possible to explain what is happening and what will happen with regard to the police acting on behalf of the Procurator Fiscal.

2. Allow the family to hold the infant (supervised) and take photographs of the child if they wish.

3. Be aware of differing cultural beliefs as suggesting photographing the dead is very offensive to some faiths.

4. Once they are ready, take a history of the circumstances of the death and including previous

medical history.

5. Explain that information will be shared with the police to provide background information to the Procurator Fiscal.

6. Explain to the family what will happen next, ie the roles of police and Procurator Fiscal and the need for a post-mortem examination by a paediatric pathologist. This may necessitate the transfer the infant body to a mortuary in a different town or city. There may also be a delay in issuing death certificate.

7. Liaise with police in providing them with the opportunity to speak with the parents at an appropriate time.

8. Explain how seeing the infant's body later on can be arranged.

9. Offer support leaflets including a parent information leaflet, local bereavement leaflets and a leaflet explaining the need for a post mortem examination.

10. Make sure parents have a contact name and number for the healthcare professional (for example paediatrician) who will provide support for them and meet with them to discuss progress.

11. You should inform the family when you will next be in touch and mention that you will arrange a future meeting date to discuss the preliminary post-mortem examination findings.

12. Ask parents if they wish you to refer them to an appropriate support organisation.

Follow up actions

Agree with the Emergency Department staff who will undertake these tasks, and if applicable to you.

1. Inform the SUDI paediatrician.

2. Inform the local area Procurator Fiscal office (on the next working day if out of hours).

3. Inform the GP immediately (next working day if out of hours). Consider telephoning NHS 24 if out of hours and asking them to contact GP the next day via the mailbox number for practice or by telephoning the named GP for the infant.

4. Make contact with the paediatric pathologist and ask what further information you can provide. Also contact the Senior Investigating Officer and ask if they require any further information. This dialogue between paediatrics, police and pathology should ensure that there is collaboration throughout the process and that the parents are supported in the best possible way without repetition of questioning from each discipline.

5. The Post-mortem examination results should be fed back to the Emergency Department consultant once you are aware of them so that the resuscitation team can be debriefed.

6. Provide information necessary for Healthcare Improvement Scotland to co-ordinate the SUDI Review meeting. The involvement of the paediatrician in the SUDI Review meeting is demonstrated in the interactive SUDI Review meeting timeline.

Ongoing involvement

Planned follow up contact with parents:

1. Contact the family within first few days to check whether they have any further questions.

2. Meet in 1-2 weeks to discuss preliminary post-mortem examination findings and the SUDI Review meeting if one is to take place (in some cases where a cause of death is identified during the post-mortem examination and there are no other factors to consider, there may be no need to hold a SUDI Review meeting).

3. Contact at 4 weeks to offer reassurance whilst waiting for ancillary post-mortem test results.

4. Contact at 6-8 weeks to offer reassurance and to check whether family are being supported. Offer contact numbers again and offer to refer them if required.

5. Contact when the final post-mortem examination report is available and to mention again that the SUDI review meeting will take place.

6. Meet with the parents 1-2 weeks after the SUDI review meeting to discuss the outcome and also encourage them to use support available and ensure that they have the relevant contact numbers. Assure them that they are welcome to make an appointment to see you again if ever they wish.

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.

Support during the next pregnancy

If a family has previously experienced a SUDI, then the following actions may help provide support.

1. Discuss with the NHS board's SUDI paediatrician plans for providing extra support for the care of the next infant, such as provision of an apnoea monitor.

2. Whenever appropriate discuss risk factors such as sleep position, co-sleeping and smoking.

3. In some areas a designated member of staff may co-ordinate the plan for additional support that a family may require for future pregnancies, working with a SUDI paediatrician/GP/ community midwife/ community health visitor to ensure that additional appointments are offered and that any additional screening is offered if appropriate.

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 a 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.