Paediatrics (SUDI)

The following sections clarify the role of the SUDI paediatrician and ensure an appropriate response 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 SUDI paediatrician through their involvement following a SUDI.

The role of the SUDI paediatrician
Interactive timeline and flow chart
Awareness of the local system
When a SUDI occurs
The role of Child Protection
Support during the next pregnancy
Staff Support
Steps and timelines around the investigation of a SUDI
The SUDI Review
Resources & External web links

The role of the SUDI paediatrician

1. There is a SUDI paediatrician nominated for each health board.

2. It is **not** a formal job title but is an added responsibility that is undertaken with the primary function to ensure a system is in place (allowing for local variation) and that relevant staff are aware of it.

3. They should oversee a process of investigation which causes the least additional upset to the parents, and include the avoidance of duplication, the provision of support and the maintenance of good communication systems.

4. A single nominated person taking overall responsibility for ensuring the system is in place is important for clinical governance and audit purposes.

Interactive timeline and flow chart

The interactive timeline demonstrates the role and responsibility of a SUDI 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) »

Awareness of the local system

A SUDI paediatrician should ensure that all staff are aware of the local established system and respond appropriately to a SUDI.

The SUDI paediatrician should:

1. Promote their role to the other professionals likely to be involved in a SUDI.

2. Identify whether the ongoing support to the family will be provided by the paediatrician who has had first contact or if the SUDI paediatrician will coordinate the SUDI process.

3. Ensure that Emergency Departments in their area are aware of the guidance and that there is a SUDI pack in each Emergency Department. Full details are given in the section for Emergency Departments.

4. Ensure that others are aware of notification systems set up to inform the SUDI paediatrician of every SUDI, for example paediatric colleagues (including neonatology for in hospital SUDI), Emergency Department, paediatric pathologists and Procurators Fiscal.

5. Ensure there is dialogue prior to each post-mortem examination between the paediatrician and the

pathologist.

6. Ensure there is planned feedback for supporting the parents.

7. Make themselves known to the local Procurators Fiscal deaths office in their area, and discuss how they wish them to help in the investigation of SUDIs. They will have their contact details for notification of each case, even if they are not personally following it up. The aim should be to achieve a proper balance between medical and forensic requirements, where there was no malicious intent.

8. Make themselves known to the senior police officer in their local police force. There may be an officer responsible for investigation of unexpected infant deaths akin to the SUDI paediatrician role. The main purpose is to discuss how police and medical inquiries can best be co-ordinated and avoid duplication of questioning of the parents.

9. Make sure parents are given their contact details as a link between all the professionals who may be involved in their care.

When a SUDI occurs

Where no hospital clinician is involved they should take direct responsibility for cases. For example if an infant is declared dead at home and does not attend the Emergency Department as per guidance.

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 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. Know who in your area is responsible for co-ordinating the plan for additional support that may be required for a future pregnancy.

2. Discuss with other professionals involved plans for providing extra support for the care of the next infant, such as provision of an apnoea monitor.

3. Collaborate with midwives and obstetricians to ensure that additional ante-natal clinic appointments are offered and that any additional screening is offered if appropriate.

4. Arrange to see the parent’s early on in pregnancy and discuss additional appointments and screening tests which may be offered.

5. Whenever appropriate discuss risk factors such as sleep position and smoking.

6. Arrange appropriate follow up clinic appointments for new infant as reassurance to parents and to check all is well.

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.

To enable Healthcare Improvement Scotland to co-ordinate the SUDI review, SUDI paediatricians may offer support in their role as link between those involved.

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.