Scottish Ambulance Service

The following sections will help ambulance personnel to respond appropriately if they are called to attend a suspected or known 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 ambulance personnel through their involvement following a SUDI.

Interactive timeline and flow chart
Main objectives for ambulance staff
National guidelines
Ongoing involvement
The role of Child Protection
Staff Support
Steps and timelines around the investigation of a SUDI
The SUDI Review
Resources & External web links

Interactive timeline and flow chart

The interactive timeline demonstrates the role and responsibility of ambulance personnel 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) »

The main objectives for ambulance staff

1. Assess whether there is any prospect of survival and initiate resuscitation or continue cardiopulmonary resuscitation (CPR).

2. Treat the family with compassion and sensitivity throughout.

3. Collect information that may help determine the cause of death.

4. Inform other agencies/ professionals as per protocols.

5. Share information as appropriate/ as requested on behalf of the Procurator Fiscal.

6. Inform the Emergency Department ahead of your arrival, and the need to hand over for continuing resuscitation if initiated. Emergency Department staff will access SUDI pack ahead of arrival.

7. Transfer the infant to the nearest Emergency Department with paediatric cover if available. If no paediatric cover, the nearest Emergency Department. In remote and rural settings there may only be the option of a local healthcare facility.

8. The infant should not be transferred directly to the mortuary.

9. If a general practitioner (GP) or police casualty surgeon has been in attendance and pronounced life extinct the infant should still be transferred to Emergency Department for examination by a paediatrician. The GP may choose to come to hospital too (this may happen in remote and rural areas).

National guidelines

In 2006 Dealing with the death of a child (including the sudden unexpected death of an infant (SUDI)) guideline was published by the UK Joint Royal Colleges Ambulance Liaison Committee (UKJRCALC).

The key points of the Guideline are:

1. Resuscitation should always be attempted unless there is a condition unequivocally associated with the death.

2. Communication and empathy are essential, and the family must be treated with compassion and sensitivity throughout.

3. Ensure the family is aware of where you are taking their infant.

4. Collect information pertaining to the situation in which you find the baby, history of events, and any significant past medical history.

5. Follow agreed protocols with regards to interagency communication and informing the police.

6. When appropriate explain that the death being unexpected, **must** be reported to the Procurator Fiscal, and that the police will act on behalf of the Procurator Fiscal in gathering information.

The UK guideline only refers to the English legal system and, whilst in Scotland the Procurator Fiscal will instruct the police to investigate, the practical application of the guidance does not differ.

In 2005 the Scottish Ambulance Service worked collaboratively with Procurators Fiscal Offices, the Association of Chief Police Officers Scotland (ACPOS), consultants in Paediatric and Palliative medicine as well as Action for Sick Children (Scotland) and The Scottish Cot Death Trust.

In response to the collaboration the Scottish Ambulance Service identified the following best practice.

1. **Remember** that all sudden, unexpected and unexplained child deaths **will require police notification** and investigation – you can assist by reassuring parents why this is necessary and that it is normal practice – it does not mean parents are under suspicion. Try not to unnecessarily disturb the site of death or potential forensic evidence. Detailed notes of events and the circumstances should be recorded and shared with police on request.

2. No child should be taken directly to a mortuary and parents should be encouraged to travel in the ambulance and to hold the child.

3. Always handle an infant as if he or she was still alive, including the use of a shawl.

4. Ask for the child’s name and use it at all times.

5. If appropriate to the circumstances, allow the parents to say goodbye and to be alone with the child.

6. Keep the parents informed – they are likely to have a number of “why” questions as well as “could we have done something better/ differently”.

7. Switch off blue lights, turn down the service radio and remove reflective jackets etc.

8. Support of relatives, neighbours, friends, GP or Police Family Liaison Officer (FLO) can be particularly helpful.

9. Your time with the family may be brief, but it can assist the family deal with the death long after the initial crisis is over. There may also be cultural sensitivities surrounding death that should be respected.

10. Remember to consider your own feelings and to discuss them with someone if that would be helpful.

Ongoing involvement

1. You will be asked by the police for background information about the infant and the mother/ father or carer. There has been agreement from the General Medical Council that due to the investigations that require to be carried out by the police on behalf of the Procurator Fiscal, information should be shared between agencies. It is recognised that duplication of questioning of parents through lack of information sharing would add to their upset. The range of questions enables as full a history as possible to taken as quickly as possible.

2. You may be contacted at several stages of the process to share relevant information.

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 final post-mortem examination report is available.

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.