|  |  |
| --- | --- |
|  |  |

**One minute guide SUDIC—Sudden Unexpected Death in Childhood**

***What is SUDIC?*** SUDIC stands for Sudden Unexpected Death in Childhood. Working Together 2018 (Chapter 5) (guide) defines this as: ‘The death of a child (less than 18 years old) that was not anticipated as a significant possibility 24 hours before the death; or where there was an unexpected collapse or incident leading to, or precipitating, the events that lead to the death’. Following the unexpected death of a child the SUDIC process is instigated by the SUDIC team.

***What is the SUDIC process?*** The SUDIC process is the Joint Agency Response to unexpected child deaths and forms part of the statutory Child Death Overview Process. The SUDIC process aims to understand the reasons for the child’s death, addresses the possible needs of other children and family members in the household and also considers any lessons to be learnt to safeguard and promote children’s welfare in the future. The decision of whether a child’s death meets the SUDIC criteria is made by the Designated Paediatrician for SUDIC and throughout the process the child remains under the jurisdiction of HM Coroner.

***Deaths which require a Joint Agency Response (JAR) are those which:***

* are or could be due to external causes.
* are sudden and there is no immediately apparent cause including Sudden Unexpected Death in Childhood (SUDIC - the death or collapse leading to death of a child which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent).
* occur in custody, or where the child was detained under the Mental Health Act.
* the initial circumstances raise any suspicions that the death may not have been natural.
* in the case of a stillbirth where no healthcare professional was in attendance.

***Aims of the JAR***

These are to:

1. Establish, as far as possible, the cause or causes of the child’s death.
2. Identify any contributory or modifiable factors.
3. Provide ongoing support to the family.
4. Ensure that all statutory obligations are met.
5. Learn lessons in order to reduce the risks of future child deaths.
6. Provide sufficient evidence to the Coroner, and where required inquest, to assist in determining the cause of death.

A Lead health professional should be assigned. This will either be the Nurse Specialist for Child Death Reviews or the Lead Doctor for The Child Death Overview Panel. This person will ensure that all health responses are implemented and be responsible for on-going liaison with the Police and other agencies. In Shropshire there is no out-of-hours health rota for a Lead health professional, therefore the role of the lead health professional should be taken up by the senior attending paediatrician.

|  |  |
| --- | --- |
| * + 1. **Dr Sam Postings, Named Doctor for CDOP & Safeguarding Children** | * + 1. **Email:** [SamJ.Postings1@nhs.net](mailto:SamJ.Postings1@nhs.net), [Shropcom.cdop@nhs.net](mailto:Shropcom.cdop@nhs.net)     2. **Telephone: 01952 567308 (Secretaries)** |
| **Bea Jones, Nurse Specialist, Child Death Reviews** | * + 1. **Email:** [Bernadette.Jones1@nhs.net](mailto:Bernadette.Jones1@nhs.net), [Shropcom.cdop@nhs.net](mailto:Shropcom.cdop@nhs.net)     2. **Mobile: 07826 901962 / 01952 580312** |
| * + 1. **Sam Wheatley, CDOP Administrator and Secretary to Head of Safeguarding** | * + 1. **Email:** [Sam.Wheatley@nhs.net](mailto:Sam.Wheatley@nhs.net), [Shropcom.cdop@nhs.net](mailto:Shropcom.cdop@nhs.net)     2. **Mobile: 07811 731984 / 01952 580387** |

***What happens in each case?*** When a child dies unexpectedly, the CDOP team are informed. They initiate an immediate information gathering, sharing, and planning discussion between the lead agencies, e.g., Health, Police, Social Care, and Education. Depending on the circumstances of the death the CDOP team will decide whether or not to visit the place where the child died. The visit should take place within 72 hours of the death wherever possible. The information relating to the circumstances of the death and the relevant health or social care history must be included in the report to the Coroner within 28 days of the child dying. Following the completion of the post mortem examination, practitioners from all the agencies involved in the deceased child’s life will be invited to another SUDIC/Information sharing meeting. The aim of the meeting is to review the information surrounding the child’s death and gather any further information that may raise concerns about safeguarding issues. Once the post-mortem report is available a final case discussion/Child Death Review meeting is held. This is usually within 12 months of the death and will be convened by the Child Death Overview Process Team. The purpose of the meeting is to share information regarding any factors that may have contributed to the death and to plan future care for the family.

***Further information can be found here:***

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf>

<https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf>