Staffordshire and Stoke-on-Trent

Multi-Agency Guidance for Joint Agency Response to Sudden and Unexpected Death in Infancy/Childhood (SUDIC)

Version 2 Dated August 2024

1.0 Introduction

This guidance summarises the key elements of the HM Government Child Death Review Statutory and Operational Guidance (England) October 2018, RCPCH Sudden unexpected death in infancy and childhood Multi-agency guidelines for care and investigation November 2016 and HM Government (2023) Working Together to Safeguard Children (chapter 6).
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
Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk)
This guidance applies to all child deaths occurring in Staffordshire and Stoke-on-Trent of children aged up to 18 years, the use of child or children within this document applies to all babies, children and young people from birth to 18 years. The same process should be used for deaths occurring in the community or hospital, while further information about the management of unexpected child deaths on Paediatric Intensive Care (PICU) is available in separate guidance.

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
  The standard JAR process is summarised in flow chart 1, the process for traumatic non-suspicious deaths in flow chart 2, and unattended stillbirth in flow chart 3. Flow charts are in section 5.

1.1 Aims of the Joint Agency Response (JAR)

These are to:

a) Establish, as far as possible, the cause or causes of the child's death.
b) Identify any contributory or modifiable factors.
c) Provide ongoing support to the family.
d) Ensure that all statutory obligations are met.

e) Learn lessons in order to reduce the risks of future child deaths.
f) Provide sufficient evidence to the coroner, and where required inquest, to assist in determining the cause of death.

2.0 Immediate actions – in the first few hours after death

2.1 Transfer to hospital

If the child has been declared dead in the community, they should be transferred with their parents to the nearest paediatric Emergency Department (ED). This also includes children and young people who die as a result of a suspected road traffic collision. Any variation in this procedure must be with full agreement between police Senior Investigating Officer and DDUD/On call paediatrician.
Children aged 16 and 17 years old may be taken to an adult ED but all other aspects of this guidance still apply. Adult ED teams should seek support from general paediatric consultants within their trust if needed.
While awaiting transfer, parents should usually be able to hold and touch their child unless there are significant forensic concerns; this should be discussed by police and ambulance staff, but is a police decision. Parents should be supervised with their child by ambulance or police staff.
If there are forensic concerns the child may be taken directly to the mortuary by the police. Again, If the child is taken the police must notify the on-call SUDIC paediatrician/DDUD at the earliest opportunity.
Locally, in the mortuary, it is not possible for SUDIC samples to be taken, the body to be examined by a paediatrician, or a medical history taken, and there will be limited support for families.

2.1 Police scene management

When a call is received by the Police that a child has been found lifeless, the first officers to be dispatched to the incident will often be uniform officers with limited experience in child death. These first responders will be responsible for initiating the Police response and taking immediate steps to meet the objectives outlined in section 1.1.

Upon initial attendance, officers should activate their body-worn cameras and take note of the environment in which the child was found, including the position and appearance of the child, initial indication as to where the child was sleeping, which persons were present, the temperature of the room, any obvious hazards, and any signs of negligent care.

If the child remains at the scene it should be ascertained whether the child has been moved, and careful consideration taken of any signs of injury.

The SUDIC Police Senior Investigating Officer must ensure that scene and body are identified and preserved. This will include the home address/location prior to death and the child (en-route and upon arrival at hospital). It is important that officers, where possible, secure the relevant address in a discreet manner, e.g. a plain clothes officer in a plain vehicle placed at the address, or family members leave the address and the premises are secured.

Officers at the death scene and at the hospital will need to commence a running scene log. If uniformed officers are the only option, then they should be placed within the home address rather than at the front door in full view.

The premises need to remain secure pending a decision by the SUDIC SIO as to the timing of a home visit or other examination. It is important that, as far as possible, the environment is left as found on attendance, to allow a joint examination of the scene to be undertaken with the DDUD. Any forensic collection should be postponed until after the SUDIC SIO and health professionals have had an opportunity to review the scene, in an undisturbed state, during a joint home visit.

2.2 Management in the Emergency Department

Once death has been confirmed, the hospital consultant paediatrician on-call must: Inform the family of the death, and ensure a member of staff is allocated to care for them.

Request the on-call Senior Investigating Officer (SIO) from Staffordshire Police Child Protection Team attends the ED.

The SIO and consultant paediatrician must jointly take a careful history of events from the family, and thoroughly examine the child's body documenting (and photographing if necessary) any injuries or other findings on a body map. Physical examination should include fundoscopy in infants where possible.

SUDIC samples should generally be taken for all non-trauma deaths of children under the age of 2 years. For children over 2 years, or any child/infant with a pre-existing life-limiting condition, clinical discretion should be used, but often microbiology and viral specimens will be taken. Of note, children taken to Queens Hospital in Burton will usually follow the Derbyshire protocol where initial samples and the skeletal survey are carried out ahead of the post mortem in Sheffield. This differs from national guidelines. Any concerns should be raised with the DDUD for South Staffordshire – Dr Mansoor Ahmed.

The document 'SUDI/Kennedy Samples – following a sudden and unexpected child and young persons death 0-18' has been created which details regional variations in scope of sample taking and can be used to aid consideration (See appendices at the end of this document entitled 'SUDI / 'Kennedy' Samples, Following a Sudden and Unexpected Child and Young Persons Death (0-18 years)).

Police officers should work with the medical staff to ensure an appropriate chain of evidence when samples are taken for forensic purposes.

The lead investigator should consider obtaining drug and alcohol samples as soon as possible from the parents/carers with informed consent If the history indicates co-sleeping or there is suspicion that the those caring for the child at the time of their death are under the influence of drink or drugs.

Usually, the clothing should remain with the child, however, when clothing, nappies or equipment have been removed, this should be retained by the police and separately bagged and exhibited.

With police consent, endotracheal tubes and lines may be removed after documentation. If there is any concern that clinical interventions may have contributed to the death, these should be left in place. If there are concerns relating to this, it should be discussed with the coroner.

Families should be able to see and hold their child in a quiet space in the ED or a special dedicated room, and this must be supervised by the police officer or hospital staff. The family or health staff should be allowed to take photographs and/or mementos; these rarely interfere with any evidence-gathering.
ED staff need to make the following notifications:
Immediate referral to social care with details of the death and that a JAR has commenced.

eCDOP notification Https://www.ecdop.co.uk/stafford/live/public
Coroner's referral
GP to be telephoned same day or next working day
Local SUDIC paediatrician/nurse (see below)

2.3 Contacting local SUDIC teams

A consultant paediatrician/Designated Doctor for Unexpected Death (DDUD) or nurse from the SUDIC team local to the child's home address should be contacted regardless of which hospital they have been taken to. The local SUDIC DDUD is responsible for all healthcare elements of the JAR that occur outside of the hospital. They should be contacted as soon as possible noting however that locally we do not have a 24 hour

provision. When possible there should be a clinical handover between ED medical staff and local SUDIC clinicians.

Contact details for teams are available in section 6.0.

In the event of the death of a child visiting the region (eg sudden death in Stafford of a child visiting from Cornwall), the Staffordshire SUDIC team would commence the JAR, conducting any visit to the scene of death; but co-ordinating closely with the SUDIC team from the child's normal residence.

2.4 Contacting social care

Shortly after the death there should be telephone discussions between Police, Social Care and the SUDIC paediatrician/nurse, to ascertain if there are any immediate child protection concerns, and to plan further stages of the investigation such as a joint home visit.

These discussions may be either a strategy meeting arranged through the Multi-Agency Safeguarding Hub (MASH) or a telephone call with the Emergency Duty Team. If a strategy meeting is held, the local SUDIC team and SIO must be informed and invited to attend.

3.0 Early actions – within first few days

3.1 Home Visit

A visit to the home or scene of collapse by police and health professional (paediatrician/DDUD/SUDIC Nurse) may be required. This can be done jointly or by child protection officers in discussion with the DDUD/SUDIC Nurse. The visit should take place as soon as possible considering the availability of professionals. Normal practice is for home visits to take place for:

- all sudden unexpected deaths of children less than 2 years
- sudden collapse and death of older children where there is no medically apparent cause
- deaths from suicide and self-harm.

Sudden deaths which are clearly due to sepsis in the absence of other concerns do not require home visits (as per RCPath-RCPCH guidelines). Other deaths may require joint home visits if there is a clear need following joint discussions by police and paediatrician/specialist nurse.

(Advice about home visits during pandemics is available at https://www.ncmd.info/2020/04/07/jar-covid-19/)

SUDIC is a rare event, but devastating for families. The home visit is an important part of the investigation and examination of sleep scenes is vital in understanding the events in infant deaths; this process can only take place with the parents /carers at their home (or wherever the final sleep took place). Home visits are also very helpful for sudden deaths of older children as this enables a detailed medical history to be obtained, or for suicides for a mental health history. Telephone consultations are not appropriate in this situation, nor relying on ED/hospital teams alone to take detailed SUDIC histories. The home visit starts the support process and gives vital information for bereaved parents. Unless there are clear forensic reasons to do so, the environment within which the infant died should be left undisturbed so that it can be fully assessed jointly by the police and health professionals, in the presence of the family.

Either at the time of the home visit or after the home visit has taken place, forensic assessment of the scenes will be undertaken by forensic scene investigators (FSI) at the direction of the SUDIC SIO. The FSI visit will normally be timed to coincide with the joint home visit by the SUDIC SIO and SUDIC paediatrician, to assist with effectively liaising and directing the FSI whilst they are both at the death scene.

The collection of bedding and clothing should be considered, but only if there are signs of forensic value such as blood, vomit or other residues. Items administered to the child and their containers e.g. medication and bottles, should be seized.

3.2 Strategy meeting

If any partner agency involved requires an urgent strategy meeting the SIO and CDOP Nurse Practitioner or hospital consultant paediatrician must be invited to ensure that full information about the circumstances of death are available. Some SUDIC will not require separate strategy meetings as the initial JAR meeting will suffice if conducted in a timely manner, providing there has been early discussion with social care as in section 2.4.

3.3 Initial JAR meeting

The Staffordshire and Stoke-on-Trent SUDIC team will arrange an initial JAR meeting as soon as possible. This should take place within 3 working days of the child's death. It is normally arranged by the CDOP Co-ordinator and chaired by the SUDIC paediatrician and should be attended by Police SIO, social worker, Coroner's Investigator, hospital consultant, GP, health visitor, school nurse or midwife, education safeguarding and any other professionals involved in the child's care. This meeting will revert to a Section 47 Strategy Meeting, chaired by Children's Social Care, if any child protection concerns arise. Parents are not invited to attend this meeting but will be informed by the SUDIC team it is taking place and the SUDIC team will feedback to parents after the meeting.

There should be discussion between the SUDIC team and Coroner's Investigator concerning timing of the Child Death Review Meeting to enable this to be held shortly after the post-mortem report is available and prior to inquest.

If the death is being managed as a suspicious death, there must still be an initial JAR meeting although this will be co-chaired by the SIO and DDUD.

3.4 Coroner's Report

The local paediatrician is responsible for writing a detailed report of the child's medical history, circumstances of death, and results of initial medical investigations. The report should be provided to the coroner and SUDIC team as soon as possible to inform the post-mortem.

3.5 Post mortem examination

If it is required and relevant, the coroner will order a post-mortem examination and skeletal survey/CT scan.
The SUDIC team should request a copy of the post-mortem report from the coroner's office promptly after the death.
In some situations, the pathologist, SUDIC paediatrician or other clinical consultant may wish to discuss clinical findings together prior to the final post-mortem report being issued; this is good practice. The coroner must be asked for permission prior to any such discussion.

3.6 Support for families

The death of a child is profoundly traumatic for families, and many will need considerable support from professionals. All families should have a named key worker as a point of contact during the JAR; this would normally be a-specialist nurse but may be from the hospital bereavement team or a police family liaison officer. All parents should be given a copy of 'When a Child Dies' and details of support organisations. Key workers should keep in contact with families while they are waiting for the results of investigations.

3.7 Welfare

Child deaths can also be traumatic and stressful for those professionals involved in the multi-agency response, whether they are involved in the emergency response or have known the child in their lifetime.

The lead police investigator should consider devising and implementing a welfare strategy to support officers and staff involved in the initial response and ongoing investigation into the death of a child. Advice can be obtained from the force occupational health and welfare services.

Hospital and ambulance staff involved in the child death response and resuscitation should be offered debriefs in accordance with local policy and access to further support as needed.

All staff involved in caring for a child who dies should have access to support through staff wellbeing services. Advice and support can be also be sought from child death specialist nurses.

4.0 Later Actions – weeks to months after the death

4.1 Release of post-mortem examination report

The coroner will send a copy of the report (provided this has been requested see section 3.5) as soon as it is available and inform the team of the date for any inquest if held. This will enable the SUDIC team to arrange the Child Death Review Meeting prior to inquest.

4.1 Child Death Review Meeting (Final Case Discussion)

This should be held when all the information is available, including the post-mortem report, usually within six months of the death, and before the Coroner's Inquest (if held). The meeting will be chaired by the SUDIC DDUD with similar attendance to the initial JAR meeting. The meeting is to review the full causes of death and analyse any factors that may have contributed, with an explicit discussion of any potential safeguarding concerns. Parents do not attend this meeting. Following the meeting, a summary and copy of the draft CDOP analysis form is sent to the Coroner.

4.2 Follow-up for families

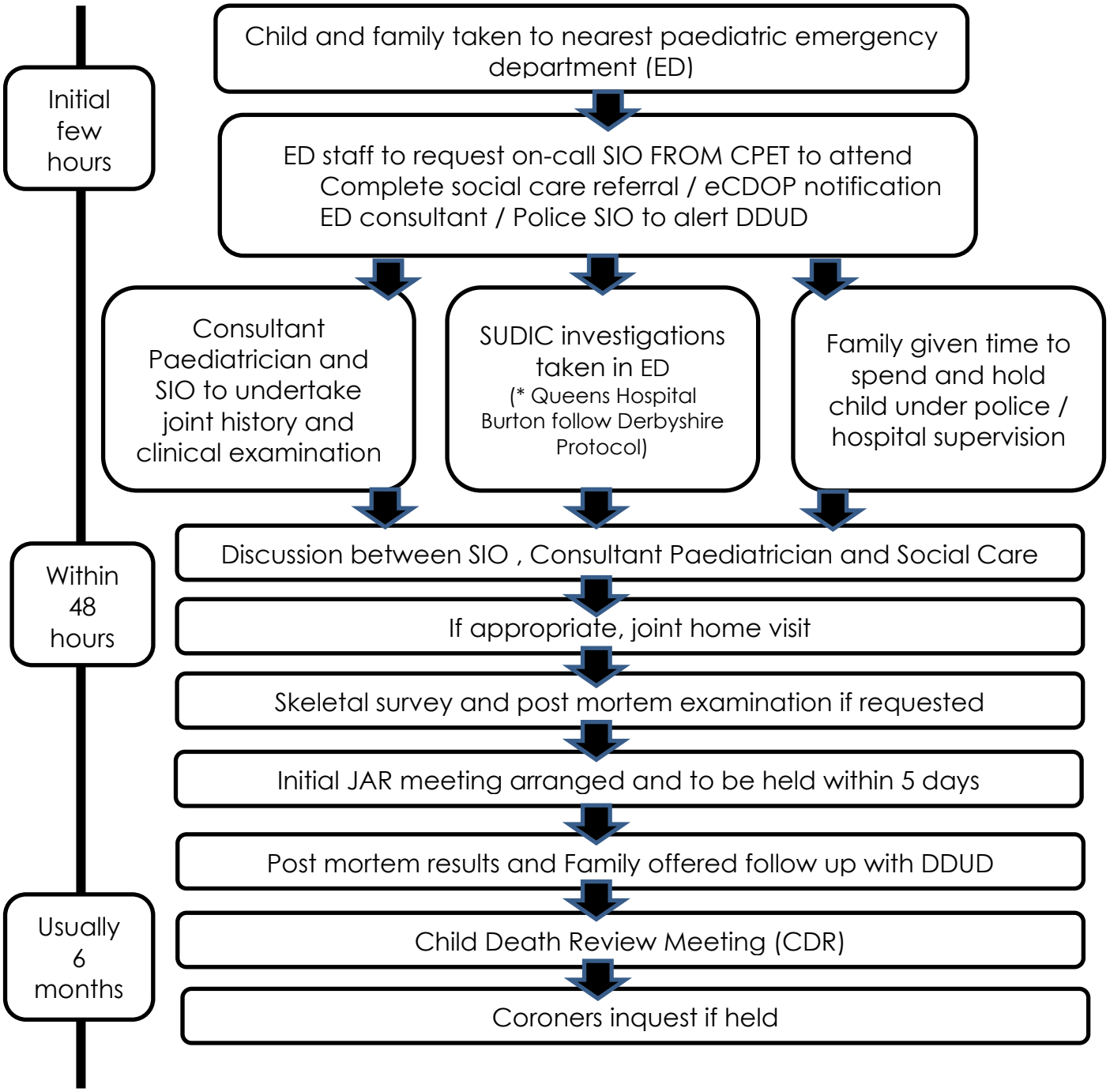
Families will want to know why their child died, and be anxious to have the results of the post-mortem examination as soon as possible. The coroner's investigator will contact families with the post-mortem results as soon as these are available, and will send a copy to the SUDIC team for information and so that the support can be offered. The DDUD/nurse will make contact with the family and will facilitate an appointment to discuss the findings and try to answer any questions that the family may have. If the SUDIC paediatrician/nurse meets with families prior to inquest they should limit their discussion to the post-mortem findings and make clear that it is the Coroner's decision as to the cause of death. If the SUDIC paediatrician/nurse is uncertain of what can or should be discussed in any particular case they should contact the Coroner for advice.

In the event that a death is subject to criminal investigation, all intended communication with the family should be discussed with the police Senior Investigating Officer first.

It is the responsibility of the Police to that all items of clothing etc. are returned to the family.

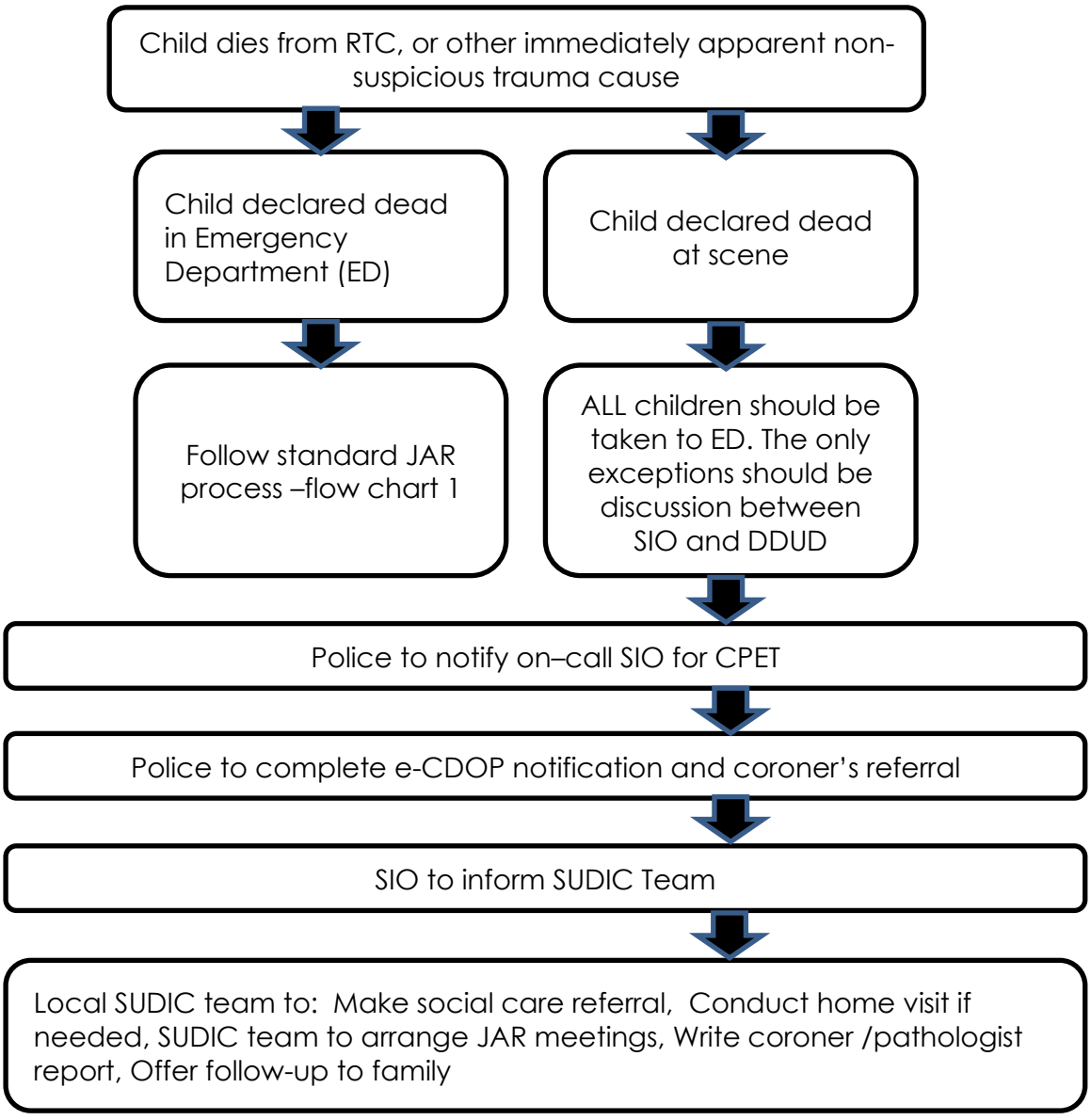
5.0 Flow charts and Appendices

Flow chart 1. Standard Joint Agency Response (JAR) to unexpected child death

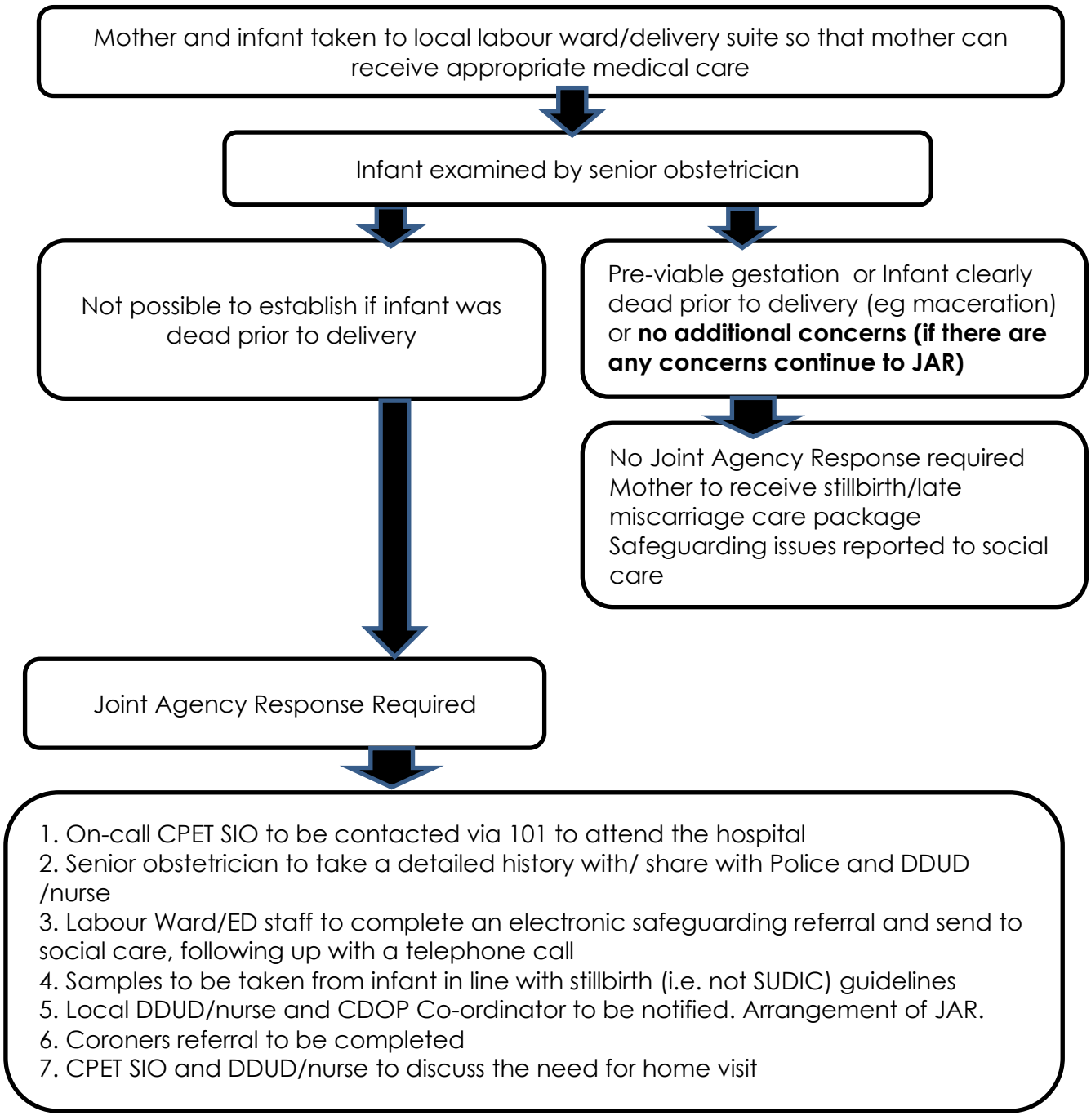


Flow chart 2. Joint Agency Response (JAR) management of child Road Traffic Collison (RTC) deaths and other immediately apparent non-suspicious trauma-related deaths

There should be a joint agency response for any child involved in a fatal road traffic collision. In these cases, a Family Liaison Officer may be appointed. The joint agency response should be appropriately tailored to the circumstances of the death, particularly where the cause of death is clear and obvious.

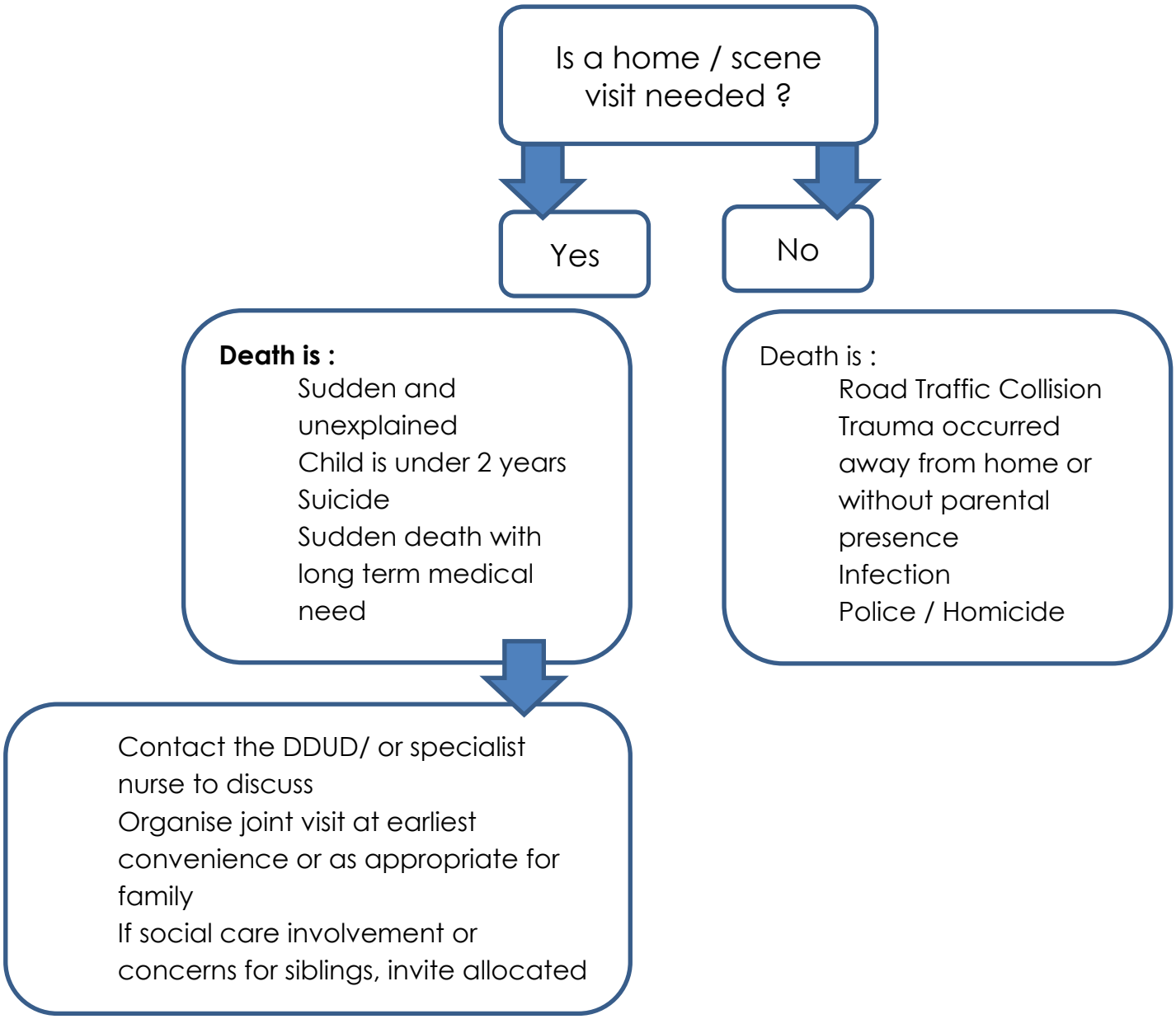


Flow chart 3. Joint Agency Response (JAR) to unattended stillbirth



There may be some unattended stillbirths in the community about which concerns have been raised, a live birth following an attempted termination of pregnancy, or an unattended live birth where the baby survived for only a short period. All of these deaths should follow the JAR process.

Flow chart 4 Joint Home Visits



Key Terminology

Child Death Review Process	The responsibilities to formally review child deaths vary across England, Scotland, Wales and Northern Ireland but all have the same objective: a multi-agency investigation that seeks to understand how and why the child died, and to identify learning with the intention of preventing future deaths.
Sudden unexpected death	It is recognised that there are many different terms used to describe the death of an infant or child. A sudden unexpected death (or collapse leading to the death) is one which would not have reasonably been expected to occur in the 24 hours previously, and where no pre-existing medical cause of death is apparent. The following terms are often used interchangeably in advice and guidance documents and may be used by other professionals to describe a death: • Sudden Unexpected Death in Infancy (SUDI) – infants up to 24 months of age 12 months • Sudden Unexpected Death in Childhood (SUDC) – children 24 months+, but under 18 years • Sudden Unexpected Death in Infancy and Childhood (SUDIC) – an umbrella term that applies to a death occurring from birth to under the age of 18 years. It is particularly important to note that some agencies define the term 'infant' as describing children between the ages of 0 to 12 months. This is because the term 'Sudden Infant death Syndrome' (SIDS) is used by medical professionals to describe circumstances as follows: SIDS is defined as the sudden unexpected death of an infant. For the purposes of this consistency within this guidance, the term SUDIC is used throughout.
Joint agency response	A joint agency response (JAR) is a coordinated multi-agency response, including an on-call health professional, police investigator and duty social worker7 . A JAR should be triggered if a child's death: • is or could be due to external causes; • is sudden and there is no immediately apparent cause; • occurs in custody, or where the child was detained under the Mental Health Act; • where 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.
Lead health professional	The lead health professional will take responsibility for ensuring that all health responses are implemented, and for ongoing liaison with the police and other agencies8 . The lead health professional will normally be the designated paediatrician for unexpected deaths in childhood, or another health professional with appropriate training and expertise in responding to child deaths. Where no out-of-hours rota for responding to unexpected infant deaths exists, the role of lead health professional should be taken by the senior attending paediatrician.

Related Guidance Documents

Child Safeguarding Practice Review Panel (2022) Guidance for Safeguarding Partners https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel

HM Government (2018) Child Death Review Statutory and Operational Guidance (England) https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england/

Royal College of Pathologists (2016) Sudden unexpected death in infancy and childhood: Multi-agency guidelines for care and investigation – second edition https://www.rcpath.org/resourceLibrary/sudden-unexpected-death-in-infancy-and-childhood-report.html

Chief Coroner's Guidance No.45 Stillbirth, and Live Birth Following Termination of Pregnancy https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-45-stillbirth-and-live-birth-following-termination-of-pregnancy/

AForeign, Commonwealth & Development Office (2022) What to do after a British National Dies Abroad https://www.gov.uk/guidance/what-to-do-after-a-british-national-dies-abroad

National Child Mortality Database (2022) Sudden and Unexpected Deaths in Infancy and Childhood https://www.ncmd.info/publications/sudden-unexpected-death-infant-child/

SUDI / 'Kennedy' Samples

Following a Sudden and Unexpected Child and Young Persons Death (0-18 years)

Locally, and regionally there are some variations in which SUDI/Kennedy samples are taken following the death of a child and young person.
Below is a list of routine suggested samples to be taken immediately after sudden unexpected deaths in infancy and childhood from the RCPCH's guidelines for care and investigation of Sudden Unexpected Death in Infancy and Children by Baroness Kennedy.

Sample	Send to	Handling	Test
Blood (serum)1-2 ml	Clinical Chemistry	Spin, store serum at -20 degrees C	Toxicology if indicated*
Blood cultures -aerobic and anaerobic 1ml	Microbiology**	If sufficient blood, anaerobic only	Culture and sensitively
Blood from Guthrie Card	Clinical Chemistry	Normal (fill in card, do not put into plastic bag)	Inherited metabolic diseases
Blood (lithium heparin)1-2ml	Cytogenetics	Normal – keep unseparated	Genetic testing (if indicated)
Cerebrospinal fluid (CSF)	Microbiology***	Normal	Microscopy, culture and sensitivity
Nasopharyngeal aspirate	Virology#	Normal	Nucleic acid amplification techniques**
Nasopharyngeal aspirate	Microbiology	Normal	Culture and sensitively
Swabs from any identifiable lesions	Microbiology	Normal	Culture and sensitively
Urine (if available)	Clinical Chemistry	Spin, store supernatant at -20 degrees C	Toxicology if indicated, inherited metabolic diseased.

Note that such samples in most cases will fall under the jurisdiction of HM Coroner, and hence communication with the coroner's office is important. Before the infant is certified to have died and/or during the resuscitation period, various samples may have been collected.

These samples should be clearly documented, the coroners officer informed, the samples secured and the results forwarded to the pathologist as soon as possible. The samples listed in the table should be taken in all SUDI cases.

In unexpected deaths in older children, the appropriate clinical samples will be guided by the circumstances of the death and clinical findings.

Notes:

Toxicology has a low yield in routine practice, and its use and coverage of substances varies according to coronial practice. Each case should be assessed individually.
Appropriate interpretation of microbiological and virological results after SUDI remains difficult, with significant variation by group and individual
If indicated based on clinical history or examination.
Samples must be sent to an appropriate virological laboratory.

Additional samples to be considered after discussion with consultant paediatrician (C)

- Skin biopsy for fibroblast culture in all cases of suspected metabolic disease.
- Muscle biopsy if history is suggestive of mitochondrial disorder.
- In suspected carbon monoxide poisoning, blood sample for carboxyhaemoglobin.

Forensic considerations (C)

- Ensure the coroner has given permission to take samples
- All samples must be documented and labelled to ensure there is an unbroken 'chain of evidence', using appropriate 'chain of evidence' proforma.
- This may mean handling samples to a police officer directly, or having the laboratory technician sign upon receiving them in the laboratory .
- Ensure that samples given to the police or coroners officer are signed for.
- Record the sites from which all samples were taken.

The following chart should be used to aid consideration. The same samples may not be required for cases and decisions should be made with the lead clinician, eg, older children who die from suspected suicide would not routinely require a skin biopsy etc. Some samples may also be sent away for processing.

Hospital / Area	Can ALL SUDI /Kennedy Samples be done at this hospital?	Can a Skeletal Survey / CT scan performed at this hospital	Post mortem sample taking / CT and Skeletal Survey
Within Staffordshire:			
Royal Stoke University Hospital	Yes. Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics. Cerebrospinal Fluid (CSF). Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, Urine (if available), Skin Biopsy for fibroblast culture	Yes. At coroners request.	
Queens Hospital Burton (part of UHDB)	No, not all samples taken at this hospital Those taken in ED as part UHDB protocol: Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics. (Only two attempts at femoral blood sampling) Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, **CSF, urine and skin biopsy are taken at post mortem**.	No	Skeletal carried out at pm (See additional extract from hospital guidance) CSF, urine and skin biopsy are taken at post mortem.
Regjonally:			
DERBYSHIRE - UHDB	No, not all samples taken at this hospital Those taken in ED as part UHDB protocol: Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics. (Only two attempts at femoral blood sampling) Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, **CSF, urine and skin biopsy are taken at post mortem**.	No	Skeletal carried out at pm (See additional extract from hospital guidance) CSF, urine and skin biopsy are taken at post mortem.
BIRMINGHAM NHS	Yes. Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics. Cerebrospinal Fluid (CSF). Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, Urine (if available), Skin Biopsy for fibroblast culture	Skeletal survey is carried out at BCH.	

Hospital / Area	Can ALL SUDI /Kennedy Samples be done at this hospital?	Can a Skeletal Survey / CT scan performed at this hospital	Post mortem sample taking / CT and Skeletal Survey
WORCESTERSHIRE Acute Hospitals NHS Trust	Yes. Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics. Cerebrospinal Fluid (CSF). Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, Urine (if available), Skin Biopsy for fibroblast culture	Yes	
HEREFORDSHIRE Wye Valley NHS Trust	Yes. Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics. Cerebrospinal Fluid (CSF). Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, Urine (if available), Skin Biopsy for fibroblast culture	Yes	
DUDLEY - The Dudley Group NHS Foundation Trust	Yes. Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics. Cerebrospinal Fluid (CSF). Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, Urine (if available), Skin Biopsy for fibroblast culture	When necessary paediatrician request pm skeletal survey and it is carried out the next available working day.	
SANDWELL: Sandwell General Hospital	Yes. Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics. Cerebrospinal Fluid (CSF). Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, Urine (if available), Skin Biopsy for fibroblast culture	Yes. Skeletal surveys are usually ordered and done the next possible slot - however, on a few occasions the coroner has arranged it at a different trust.	
WALSALL: Walsall Healthcare Trust	Yes. Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics. Cerebrospinal Fluid (CSF). Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, Urine (if available), Skin Biopsy for fibroblast culture	Yes	
WOLVERHAMPTON: Royal Wolverhampton Trust	Yes. Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics.	Yes- Skeletal survey can be completed but CT is not which would be indicated in SUDIs under 2yrs.	

	Cerebrospinal Fluid (CSF). Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, Urine (if available), Skin Biopsy for fibroblast culture	No local practitioners have relevant training.	

Hospital / Area	Can ALL SUDI /Kennedy Samples be done at this hospital?	Can a Skeletal Survey / CT scan performed at this hospital	Post mortem sample taking / CT and Skeletal Survey
COVENTRY, SOLIHULL AND WARWICKSHIRE	Yes at all 3 hospitals. Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics. Cerebrospinal Fluid (CSF). Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, Urine (if available), Skin Biopsy for fibroblast culture	At two of the three hospitals yes, with the third trust they would be transferred for this.	
SHROPSHIRE: Shropshire Community Health	Yes. Blood sample taken for - toxicology - Cultures - inherited metabolic disorders - genetics. Cerebrospinal Fluid (CSF). Nasopharyngeal aspirate for : - microbiology - virology Swabs for microbiology of any lesions, Urine (if available), Skin Biopsy for fibroblast culture	Skeletal survey can be done hospital and sometimes it is taken as part of the pm at the hospital they are taken to.	

Of note:

By exception, UHDB (locally Queens Hospital, Burton) follow guidelines established with paediatric pathologists in Sheffield, which is the usual route for children who die suddenly and unexpectedly and are taken to Queens Burton or Royal Derby Hospital. Blood, nasopharyngeal aspirate and swabs are carried out for all unexpected deaths in ED at the hospital. Cerebrospinal fluid (CSF), skin biopsy and urine are captured at post mortem examination.

6.0 Staffordshire and Stoke-on-Trent Contacts for Child Death Review teams for local SUDIC investigations .

Staffordshire and Stoke on Trent SUDIC Team
Staffordshire Police: 101

South Staffs

SUDIC investigation is usually available Monday to Friday during working hours from the Designated Doctor, Dr Mansoor Ahmed. Dr Ahmed may be available for advice out of hours. Email: mansoor.ahmed2@nhs.net.

Nurse Practitioner for Child Death Overview Process South Staffordshire – Sue Necklen 07551152793. Email: sue.lloyd@staffsstoke.icb.nhs.uk

CDOP Co-ordinator: Faith Lindley-Cooke mobile: 07543662992 , E-mail: faith.lindley-cooke@staffordshire.police.uk

North Staffs and Stoke on Trent

SUDIC investigation is usually available Monday to Friday during working hours from the Designated Doctors. There are three for N Staffs and SOT: Dr Evelyn Chia, Dr Alex Tabor, and Dr Caroline Groves. Please contact the Paediatric Co-ordinator :Deborah Williams on 01782675292 or CDOP Co-ordinator.

Dr Evelyn Chia Email: evelyn.chia@uhnm.nhs.uk, Dr Alex Tabor Email: Alexandra.tabor@nhs.net, Dr Caroline Groves email: caroline.groves@nhs.net

CDOP Co-ordinator: Faith Lindley-Cooke. mobile: 07543662992 , E-mail: faith.lindley-cooke@staffordshire.police.uk

Clinical Nurse Specialist – Sudden Unexpected Death in Infants and Children for North Staffordshire and Stoke-on-Trent - Rebecca Bache. Email: Bekki.Bache@uhnm.nhs.uk

Contact Details all correct at August 2024

Black Country (Dudley, Sandwell, Walsall, Wolverhampton)

Black Country Child Death Overview Panel Coordinator: Keren Hodgson, Email: keren.hodgson@nhs.net; Phone: 07557 813388
Black Country Child Death Overview Panel Officer: Michelle Mincher Email: michelle.mincher@nhs.net; Phone: 07812 488012
(Monday – Friday, working hours only – no cover on weekends, bank holidays or out of hours)
Notify all Black Country Deaths to: www.ecdop.co.uk/BlackCountry/Live/Public
Local SUDIC Processes

Dudley:

Designated Doctor for Child Death DGFT – Dr Subramanian Mahadevan: s.mahadevan@nhs.net

Lead Practitioner for Child Mortality - Bev Tinsley: btinsley@nhs.net
Child death Admin for DGFT – Louise Jones: louise.jones154@nhs.net - 01384 244361
Generic Email Safeguarding team: dgft.safeguardingteam@nhs.net
Joint Agency Response available Monday to Friday working hours; switchboard - 01384 456111 - will contact the Lead Practitioner for Child Mortality or the Safeguarding Team.
Out of hours: Rota includes Lead Practitioner for Child Mortality and members of the Safeguarding team – via hospital switchboard – 01384 456111

Sandwell:

Designated Doctor for Child Death SWBH - Dr Charlotte Avann: charlotte.avann@nhs.net;
Child Death Admin for Sandwell – Kirsty Jordan: Kirsty.jordan1@nhs.net
Joint Agency Response - The first point of contact to report a SUDIC - SWBH switchboard 0121 554 3801/0121 553 1831. If the death occurs Monday to Friday in working hours, Switchboard will contact the Lead Nurse for Child Mortality (BCICB) and the Designated Doctor for Child Death for advice, guidance and support.
Out of hours: The Acute Consultant Paediatrician on Call for SWBH who will be able to give advice and guidance, via hospital switchboard – 0121 554 3801/0121 553 1831
Please note: Lead Nurse for Child Mortality BCICB (Debbie Brown/Kerris Percival and/or Designated Doctor for Child Death happy to advise/liaise with the Acute Consultant Paediatrician on call. (debbie.brown2@nhs.net / k.percival1@nhs.net)

Walsall:

Designated Doctor for Child Death Walsall - ICB - Dr Bashir Muhammad: bashir.muhammad@nhs.net;
Lead for Child Death WHT - Dr Tamsin Lane: tamsinlane1@nhs.net
Team Secretary for Child Mortality in WHT - Mindra Kumar: mindra.kumar1@nhs.net - 01922 721172 (ext:7404)
Joint Agency Response - The first point of contact to report a SUDIC – WHT switchboard - 01922 721172.
Out of hours: SUDIC investigation is provided 24/7 by the acute general paediatric consultants via hospital switchboard – 01922 721172

Wolverhampton:

Designated Doctor for Child Death Wolverhampton - Dr Cath Williams: catherine.williams15@nhs.net
Lead for Child death RWT – Dr Lorna Bagshaw: lorna.bagshaw@nhs.net
Specialist Nurse for Child Deaths – Current Vacant position
Child Death Administrator for RWT - Abbey Robbins: abbey.robbins@nhs.net - 01902 446316
Joint Agency Response - The first point of contact to report a SUDIC – RWT switchboard - 01902 307999 and ask for the child protection on call Consultant. SUDIC investigation is provided 9am-5pm, 7 days a week by the Consultant Paediatrician on call for Child Protection and Child Deaths.
Out of hours: Advice may be available from the acute general paediatrician on–call, via hospital switchboard – 01902 3017999

Birmingham and Solihull Child Death Review Team

Birmingham and Solihull- There is an On-Call SUDIC Paediatrician 24/7, 365 days a year, contactable via BCH switchboard on 0121 333-9999.
Lead nurses for Child Death Review for Birmingham *and* Solihull: Sue Cope 07388 714171 and Sarah Ashburn 07739631561, Bea Jones 07717539923(Mon-Fri 9-5).
Birmingham and Solihull CDOP Co-ordinator: Melisha McKenzie 07585 104 611
Child death review team administrators: Jo Fox 07845 055 269 & Helen Foster 07775 469535 (Mon-Fri 9-5)
Notify all Birmingham and Solihull child deaths to:
https://www.ecdop.co.uk/BirminghamAndSolihull/Live/Public
CDRT email account : nhsbsolicb.childdeathreviewteam@nhs.net

West Midlands Police:

To contact the on-call DI for SUDIC between 8am and 10pm everyday, call Ladywood Public Protection Unit – 101 ext 8626037. Outside these times call 101 and ask for on-call DI for child abuse/child death – if you can't get through 101 use 999.

Coventry and Warwickshire

SUDIC service is provided by Consultant general paediatricians based at University Hospital Coventry and Warwickshire, contact via UHCW switchboard 02476 964000. SUDIC leads are Dr Karen McLachlan, Dr Brian Shields and Dr Deborah Hilton. SUDIC cover is not available 24 hours.
CDOP Senior Officer : Leannda Lawrence
E-mail: leanndalawrence@warwickshire.gov.uk

CDOP CENTRAL email: cdopcsw@warwickshire.gov.uk

Shropshire, Telford & Wrekin

Sarah Gray interim Specialist Nurse for Child death available for Joint Agency SUDIC investigation Monday to Friday, 9am to 5pm and out of hours there is no-on call arrangement for SUDIC. Advice is available from the acute paediatrician on-call at Shrewsbury and Telford Hospitals Trust (SaTH)
Designated Doctor – vacant
Child death administrator – vacant
Sarah Gray sarahgray3@nhs.net
Child death service contact number 07917010518
Generic email address: Shropcom.cdop@nhs.net

South Warwickshire

These arrangements are currently in transition. Contact the on-call consultant general paediatrician at University Hospital Coventry and Warwickshire via switchboard 02476 964000. CDOP contact details as per Coventry and Warwickshire.

Herefordshire:

SUDIC investigation is provided 24 hours by the acute general paediatric consultants, contactable via hospital switchboard, 01432 355444
SUDIC lead, Dr Simon Meyrick, Consultant paediatrician, Hereford County Hospital contactable via hospital switchboard, 01432 355444. E-mail: Simon.meyrick@nhs.net.
Herefordshire and Worcestershire CDOP Co-ordinator Polly Lowe 01905 843199 plowe@worcestershire.gov.uk cdr@worcestershire.gov.uk
Herefordshire and Worcestershire CDOP Administrator Jayne Williams cdr@worcestershire.gov.uk

Worcestershire

SUDIC investigation is provided by the SUDIC nurses 7 days a week from 0830-1630, out of hours this is provided by the on-call Consultant Paediatrician. The on-call nurse or consultant is contacted via hospital switchboard: Worcester Royal Hospital 01905 763333, Alexandra Hospital Redditch: 01527 503030.
SUDIC lead Nurse Donna Steward 07912784135 d.steward1@nhs.net
Designated Doctor for Child Death, Dr Jenny Edmunds 01905 681058 07841535154/07764 766 469 jennifer.edmunds@nhs.net
SUDIC Administrator Tina Randle tina.randle@nhs.net.
Herefordshire and Worcestershire CDOP Co-ordinator Polly Lowe 01905 843199 plowe@worcestershire.gov.uk cdr@worcestershire.gov.uk
Herefordshire and Worcestershire