

01 Background



There is a **statutory requirement** for LSCBs to have a **coordinated response** to SUDC. This means that all professionals in Lancashire have a **duty to cooperate** and use this protocol. The protocol has been operating in Lancashire in different forms since 2009.

This briefing is to ensure that professionals know what to do in case of a **sudden death of a child**.

Each death has to be responded to within **24 hours**. It is important that there is a coordinated response in order to **minimise distress** on the worst day of their lives and ensure that the **family are well supported** and know what is going to happen.

Why it matters 02

Initiating the process correctly from the outset means that families get to know the SUDC nurse so they can **build a relationship** throughout the process, which helps the family to manage the process. The support process can last till the inquest, if needed. Lack of coordination can mean that services are not coordinated, meaning that the family have an unnecessarily distressing day repeating information.

If SUDC nurses are involved from the start, they can **support police in investigation** gathering crucial information from a health perspective.



03



Information

Definition of **unexpected death**

"An unexpected death is defined as the death of a child or infant (**less than 18 years old**) which

- Was **not anticipated** as a significant possibility for eg **24 hours before the death**; or

- Where there was a similarly **unexpected collapse or incident** leading to or precipitating the events which led to the death". (Working Together 2015)

In Lancashire, the lead SUDC nurse, specialist SUDC nurse coordinate the multi-agency rapid response process. The **SUDC protocol** can be found on LSCB procedures. Within the protocol, the **roles of different agencies** are set out.

05



04

07

Questions to consider

Are we clear about what an **unexpected death** is?

Are we all clear about what is expected of us if we learn of an unexpected death? (e.g. who to notify)

Do we know **where to go** for extra information.

06



What to do

1. Ensure you know **how to find the protocol**

2. Do the **e-learning** if you would like more detail

3. **Face to face Training** if involved in the response to a unexpected death of a child

4. Know **who to notify** so that the process gets started promptly so as to minimise distress.

It gives roles for: Police, Coroner, Social care, Ambulance Service, Hospital staff, GP, Community health professionals, Midwives, Pathologists, and SUDC nurses.

There is also guidance on parent support and communication.

