7-Minute Briefing: Multi-Agency Response to Sudden Unexplained Critical Childhood Illness or Death Guidelines

1. Background

Every child who dies deserves to be treated with respect and care; to ensure a consistent high-quality approach to undertaking child death reviews in Scotland. National guidance was published by Health Improvement Scotland in 2021, which established a system for reviewing and learning from the circumstances surrounding the deaths of all children and young people in Scotland. A National Hub was subsequently set up to co-ordinate all Child Death Review (CDR) activity across Scotland.

2. Why might this guideline be required?

The purpose of this guideline is to ensure Dumfries and Galloway have processes in place which outline and navigate all stages of the review process; from notification, carrying out the review, to sharing the learning locally and nationally.

It provides clear guidance to all multi-agency staff in Dumfries and Galloway who respond to sudden and un/explained critical childhood illness or deaths, ensuring compliance with legislation.

3. What does this guidance provide?

These guidelines provide a framework for professionals in responding to all unexpected deaths in children from birth (excluding stillbirths) to age 18 and 25 where the young person was Care Experienced. This includes unexpected deaths in the early neonatal period, unexpected deaths for which a natural cause is not immediately apparent, and deaths from external causes, including accidents, suicides and possible homicides.

4. The Process - Immediate

A multi-agency approach is key to the effective investigation of an unexpected death and to support for the family.

MASH Managers should be informed.

Information sharing and planning discussion should take place between the lead professionals (Health, Ambulance crew, Social Work and Police) before the family leave the Emergency Department.

5. The Process – Subsequent

A further information sharing and planning MASH Management meeting should usually be held within normal working hours.

Consideration should be given to the safety and wellbeing of any other children in the household. An Inter-agency Referral Discussion may need to be convened.

6. Child Death Commissioning Group

Immediate actions to support and protect any remaining siblings and/ or family members should be considered within either a MASH Managers and/ or a Multi-Agency Support and Response meeting as necessary. In parallel to these meetings, NHS Dumfries and Galloway will arrange a Child Death Review Commissioning meeting to discuss the circumstances of the child's death, identify any support needs of the family and agree what type of review should be undertaken.

7. Resources

National-Hub-National-Guidance-October-2021.pdf (healthcareimprovementscotland.scot)

All processes required for health staff in response to SUDI are detailed in the SUDI guidance and support documents – Healthcare Improvement Scotland.