One minute guide

SUDIC—Sudden Unexpected Death in Childhood

No. 109, April 2024

What is SUDIC?

SUDIC stands for Sudden Unexpected Death in Childhood which is defined as:
The death of a child (less than 18 years old), or a collapse/ incident leading to death, that was not anticipated as a significant possibility 24 hours before 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, or Joint Agency Review (JAR), is the multi-agency response to unexpected child deaths and forms part of the statutory Child Death Review Procedures set out in Chapter 6 of Working Together to Safeguard Children (2023).

The SUDIC process aims to understand the reason(s) for the child's death, address the needs of other children and family members in the household and also consider 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 SUDIC Paediatrician and throughout the process the child remains under the jurisdiction of HM Coroner.

What is the SUDIC team?

The SUDIC team, which sits within Leeds Community Healthcare Trust, is led by the SUDIC Paediatrician(s) and SUDIC Nurse, supported by the SUDIC Administrator and Safeguarding Team. The team takes responsibility for facilitating the Joint Agency Review (JAR) in response to the sudden and unexpected death of a child living in Leeds.

The team work closely with the Accident & Emergency Department, Police, Coroner's Office and Yorkshire Ambulance Service.

The team work to the Royal College of Paediatrics and Child Health guidelines for Sudden unexpected death in infancy and childhood.

What happens in each case?

When a child dies unexpectedly the SUDIC team are informed, at which point the team obtain as much information as possible about the circumstances of the child's death from the informant.

The SUDIC team will usually arrange to visit the place where the child died, where appropriate, within 72 hours of the death.

Following the visit, practitioners from all the agencies involved in the deceased child's life will be invited to an Initial SUDIC Meeting. The aim of the meeting is to gather as much information as possible in relation to the child's death and any further information relevant to the family's needs.

The information relating to the circumstances of the death and the relevant health, police or social care history must be included in the report to the HM Coroner within 28 days of the child dying.

Once the post-mortem report is available a Final Case Discussion meeting is held. The purpose of the meeting is to share information regarding any factors that may have contributed to the death and to enable the professionals involved to plan future care for the family.

Following the meeting, a Final SUDIC Report, completed by the SUDIC Paediatrician, is sent to HM Coroner and to the Administrator of the Leeds Child Death Overview Panel.

Key contacts and for more information

The SUDIC Team can be contacted on tel: 0113 8430210 (during office hours).
To inform the team of the death of a child tel: 0113 8430212 (24hr answerphone)

Further information is available from the Leeds Community Healthcare SUDIC webpage and the West Yorkshire Consortium Inter Agency Safeguarding and Child Protection Procedures

One minute guides homepage

Making Leeds a child friendly city