Paediatric Matters
Quarterly publication by the Queensland Paediatric Quality Council
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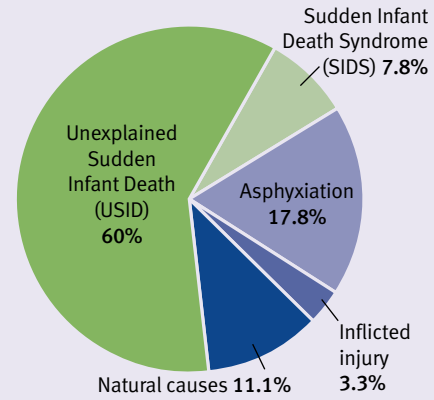
Sudden Unexpected Deaths in Infancy (SUDI) - Part 2

Fast facts*

Total SUDI cases reviewed n=90



77% of SUDI occurred in the usual place of residence. 20% of SUDI occurred while visiting family or friends or while on holidays.

57% of infants were taken to hospital either by ambulance or family. 43% of infants were declared deceased at the scene of the incident by paramedics.

Elisha's story

This story is continued from Paediatric Matters Edition 3 and follows baby Elisha (aged 9 weeks) after her parents Lara and Troy found her unresponsive in their bed.

Queensland Ambulance paramedics arrived soon after the 000 call. Elisha was pale with no pulse and no respiratory effort. The paramedic team commenced resuscitation and transported Elisha and Lara to hospital.

On arrival at the Emergency Department (ED) Elisha remained in cardiorespiratory arrest and resuscitation was continued. Troy arrived in the ED. After more than 30 minutes without return of circulation, resuscitation was ceased. Elisha's parents were brought into the resuscitation room and gently informed.

A support nurse helped the family move to a nearby quiet room where they had time together with Elisha for memory making with photos and footprints.

The senior doctor spoke with the family. Elisha had not had contact with health services so little was documented about her health and development. The need to report Elisha's unexplained death to the Coroner was explained to her parents, as was the need to take relevant family and infant health histories to assist in identifying possible reasons for her death. They agreed to a later meeting with a social worker and paediatrician to complete the interview and provide support. The hospital social worker then met with the family to address their immediate needs.

The Ambulance Service had notified Queensland Police of the 000 call, and hospital staff also called police to report the death. Two Detective Sergeants from the Child Protection Investigation Unit (CPIU) arrived at the ED and met with staff to obtain particulars of the events surrounding Elisha's death. The officers then met with Lara and Troy to discuss the events leading up to Elisha being brought to hospital. The officers transported Lara and Troy back to their house so they could view where the sleeping incident had occurred. The police organised scene photography (including video), and detailed scene description especially of the bedding, and submitted appropriate notification to the Coroner.

The Coroner ordered a full forensic autopsy including CT scan, histology, toxicology and testing for infection and metabolic causes. The findings included mild inflammation of the upper airway tissues and mild congestion of the lungs. All other tests were negative. The pathologist viewed the police report including photographs of the bedding, the brief records of Elisha's birth, and the detailed history collected at the paediatrician interview. He concluded the cause of death was "Undetermined", as there was no conclusive cause of death found, and the circumstances of death suggested that the baby's position relative to the pillow in the sleep environment may have made asphyxiation possible. The hospital social worker and the Child Safety Services maintained contact with Lara and Troy to monitor the health and well-being of the family including Elisha's siblings.

Key points

Police have a dual role of criminal and coronial investigation when initially investigating SUDI deaths until they are satisfied no crime has been committed.

Queensland Police task a Detective Sergeant from CPIU or an experienced Detective from Criminal Investigation Branch to investigate SUDI.

A thorough infant health history is very important to improve investigation of the death.

Family support following the death is critical and usually includes:

- bereavement counselling
- liaison with forensic services for process updates and autopsy results
- referral to services such as RedNose and community child health
- medical follow-up regarding possible genetic issues, sibling health, future pregnancy

QPQC actions

Standardised infant health history form under development.

Multiagency work to improve the investigation of SUDI deaths.

Improved notification to HHSs of a SUDI to facilitate family support.

For further information on the classifications used see the QPQC Review of 2013 Queensland Post-Neonatal Infant Deaths: Queensland State Summary Report.

** Based on QPQC review of SUDI deaths in Queensland 2013–14*