Sudden Unexpected Death in Infancy (SUDI) in NSW Health Facilities

Summary This Policy Directive outlines the mandatory requirements for management of sudden unexpected death in infancy (SUDI) in NSW Health facilities. It outlines the role of NSW Health in the context of the NSW Government response to SUDI which includes the NSW State Coroner and NSW Police.

Document type Policy Directive

Document number PD2025_045

Publication date 09 December 2025

Author branch Health and Social Policy

Branch contact (02) 9391 9000

Replaces PD2019_035

Review date 09 December 2030

Policy manual Patient Matters Manual for Public Health Organisations

File number DG18/5750

Status Active

Functional group Clinical/Patient Services - Baby and Child, Medical Treatment, Nursing and Midwifery

Applies to Ministry of Health, Public Health Units, Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, NSW Health Pathology, Public Health System Support Division, Government Medical Officers, Community Health Centres, NSW Ambulance Service, Public Hospitals

Distributed to Ministry of Health, Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Audience All Staff of NSW Health

Secretary, NSW Health

NSW Health

Policy Directive

Sudden Unexpected Death in Infancy (SUDI) in NSW Health Facilities

Policy Statement

NSW Health is committed to a compassionate and coordinated response to sudden unexpected death in infancy (SUDI). This Policy Directive outlines the mandatory requirements for management of SUDI in NSW Health facilities. It also outlines the role of NSW Health in the context of the NSW Government response to SUDI which includes the NSW State Coroner and NSW Police.

Summary of Policy Requirements

SUDI is a reportable death under the *Coroners Act 2009* (NSW). Most SUDI occur in the community and are brought to their local emergency department, however, SUDI can also occur in hospital.

Information should be clearly visible for staff on how to contact the:

- SUDI Case Manager for each facility
- on-call Forensic Medicine Clinical Nurse Consultant (CNC)
- Forensic Medicine social worker
- on-call or networked paediatrician
- hospital or on call social worker
- Aboriginal Health professional with a designated cultural support role
- Child Abuse and Sexual Assault Advice Line (CASACAL)
- Police Area Command.

A staff member or staff members must be nominated as SUDI Case Manager. This role is in addition to any existing responsibilities of the staff member(s). Depending on the resources available to each facility, this might include the health service manager in small facilities, social worker/s or other suitable qualified professionals. The SUDI Case Manager will provide support to the parents/carers and coordinate completion of documentation required by NSW Health. A list of roles and responsibilities of agencies and staff involved in the SUDI response is available.

SUDI Case Managers will receive training in:

- SUDI policy and protocols
- trauma informed care

- cultural competence
- child wellbeing and protection.

Adequate resources and education are to be provided so that staff can meet the needs of the family no matter where they present, and that parents/carers have access to expert medical advice, nursing care and social work.

A suitable private space must be made available within each health care facility, for families to sit with their deceased infant (with supervision) and, if appropriate, have their infant's medical history taken.

Stages 1 and 2 of the infant's medical history are to be completed by a paediatrician or senior medical officer/visiting medical officer and documented in the medical record. All sections of the Medical History Template should be completed. A copy of the infant's medical record must be forwarded to Forensic Medicine (NSW Health Pathology) on or before the next business day after the infant's death.

Support must be available for staff who provide care to infants and parents/carers who have experienced SUDI. If necessary, this can be accessed via locally networked paediatric services.

Additionally, there must be processes to maintain the quality of care and patient experience in SUDI cases. This includes incident notification, documentation, case discussion with input from parents/carers and staff, and implementation of any identified improvement opportunities.

Revision History

Version	Approved By	Amendment Notes
PD2025_045 December-2025	Deputy Secretary, Health System Strategy and Patient Experience	Key updates strengthen coordination, compliance, and family support: • An additional role of SUDI Case Manager added to the responsibilities of designated existing staff in each hospital. • Additional advice regarding care for families, including culturally appropriate care for Aboriginal parents/carers, CALD families and young families. • Medical History offered in 2 stages – immediate and on next business day. • A cross-agency huddle to be held at completion of the immediate response in hospital.
PD2019_035 July-2019	Deputy Secretary, Health System Strategy and Planning	Updated policy directive replaces PD2008_070 Death Management of Sudden Unexpected Death in Infancy.
PD2008_070 December-2008	Secretary, NSW Health	
PD2005_493 February-2005	Director-General	

Contents

1. Background

In a retrospective NSW Health audit covering 21 months through 2020 and 2021 in NSW, 75 infants under the age of 12 months were reported as having died suddenly and unexpectedly, with a cause unable to be determined.[1] The death of a baby is an immensely distressing and traumatic event for families, which requires a trauma-informed response.[2]

SUDI requires thorough investigation which includes taking a systematic and comprehensive medical and social history of the infant and related family members. Determining a cause of death is important for parents and their future children, as well as for prevention, public health policy, and research into the risk factors for SUDI.[3]

However, a sudden unexpected death in infancy (SUDI) is a rare event, with many hospitals seeing one or none over a 21 month period.[4] Therefore, clear direction is required to support NSW Health staff to respond appropriately to a SUDI.

In NSW, a SUDI requires a cross-agency response from NSW Health (specifically NSW Health facilities, NSW Ambulance and NSW Health Pathology), NSW Police, Department of Communities and Justice (DCJ) and the NSW State Coroner.

1.1. About this Policy Directive

This Policy Directive mandates NSW Health response to a SUDI and applies to:

- When an infant is brought to a NSW Health facility, following a sudden, unexpected death.
- When an infant is brought to a NSW Health facility after an unexpected out-of-hospital cardiac arrest with return of spontaneous circulation (ROSC) and dies in hospital.
- When there is a sudden, unexpected infant death during a hospital admission, including if the death occurs in a maternity or neonatal ward.

NSW Health's role in the management of SUDI includes:

- Care of the infant, siblings and parents/carers.
- Completion of the infant's medical history, with a copy of the infant's health care record and completed Medical History Template – SUDI (refer to Section 7.2) forwarded to Forensic Medicine (NSW Health Pathology) the next business day after the infant's death.
- Completion of the post-mortem examination and liaison with other agencies involved in the coronial process.
- Participation in the NSW Government response to SUDI. A table that outlines NSW Health's role and other agencies in the SUDI response can be found at Section 6.

The SUDI response outlined in this Policy Directive aims to:

- Ensure parents/carers and their families are offered support during and beyond the immediate aftermath of the death of their baby.

- Ensure young parents/carers under the age of 18 and their families are provided care which aligns with the Child Safe Standards.
- Ensure the cultural and religious beliefs of families are respected and accommodated where possible.
- Ensure all families receive culturally safe care during and beyond the immediate aftermath of the death of their baby, especially Aboriginal families and families who are culturally and linguistically diverse.
- Establish where possible, the cause of death and assist parents/carers and their families to understand how and why the death may have occurred.
- Provide parents/carers with information about any potential health risks for other family members.
- Ensure timely and comprehensive completion of the infant's medical history. A template to support completion of the infant's medical history is attached at Section 7.2 – Medical History Template – SUDI.
- Support Forensic Medicine to complete the post-mortem examination and coronial process, including providing information to inform future SUDI prevention activities for NSW Health and other agencies.
- Ensure that statutory obligations are met by adhering to the NSW Health Policy Directive *Child Wellbeing and Protection Policies and Procedures for NSW Health* (PD2013_007) in relation to surviving siblings/ other children in the household.
- Ensure that statutory obligations are met by adhering to NSW Health Policy Directive *Coroners Cases and Coroners Act 2009* (PD2024_036). This includes assisting the NSW State Coroner (Coroner) and NSW Police in their role of investigating the infant's death.

1.2. Implementation

Local health districts (LHDs) and specialty health networks (SHNs) are to develop an implementation plan for SUDI presentations at each facility with an emergency department within their district or network. The plan must comply with this Policy Directive, identify the required roles of health professionals in relation to a SUDI, and be communicated to local representatives of Ambulance NSW, NSW Police Force Area Command (metro) or Police District (regional) and the Department of Communities and Justice.

LHD and SHN chief executives are responsible for:

- Assigning responsibility, personnel and resources to implement this Policy Directive.
- Ensuring key roles, such as SUDI Case Managers and paediatricians, receive necessary training for a SUDI response.
- Establishing mechanisms to ensure the mandatory requirements in this Policy Directive are applied, achieved and sustained as standard practice when a SUDI occurs. This should include the nomination of an executive sponsor.

- Ensuring that any local policy is fully compliant with this Policy Directive and is developed in consultation with the hospital executive, clinical governance unit, and clinical staff.

1.3. Key definitions

Child Abuse and Sexual Assault Advice Line (CASACAL)/Child Protection Unit/Team	An advice line staffed by specialist Child Protection Paediatricians from NSW Health's tertiary child protection units/team. Throughout this Policy Directive the term CASACAL also refers to the Child Protection Unit or Team where workers are in facilities with a tertiary child protection service.
eMR	Electronic Medical Record. The terms eMR and medical record used interchangeably.
Forensic Medicine Clinical Nurse Consultant (CNC)	Forensic Medicine Clinical Nurse Consultants (CNCs) provide educational support and guidance to paediatricians prior to the SUDI medical history taking, subject to their availability. Forensic medicine CNCs may also provide consultancy to healthcare clinicians involved in the management of a SUDI. This consultation may include providing guidance on the definition of a SUDI, policy requirements, completion of the SUDI medical history and alternate pathways if it is established if this was not in fact a SUDI
Forensic Medicine social worker	Forensic Medicine social workers provide support for bereaved families following referral from the LHD/SHN. While the coronial process is ongoing, up until after the final post-mortem report has been discussed, parents/carers who have experienced the sudden unexpected death of an infant can access support, advice and referral to other services from the Forensic Medicine social work team.
Hot debrief (HDB)	An interactive, structured team dialogue that takes place either immediately or very shortly after a clinical case.
Infant/baby	For the purposes of this Policy Directive, an infant under the age of 12 months. In this Policy Directive the terms "infant" and "baby" are used interchangeably.

Sudden Infant Death Syndrome (SIDS)	The sudden, unexpected death of an infant: • less than 12 months of age with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including performance of a complete autopsy, review of the circumstances of the death and the clinical history.[6]
Sudden Unexpected Death in Infancy (SUDI)	The sudden, unexpected death of an infant: • less than 12 months of age, and • where the cause was not immediately apparent at the time of death. This definition excludes infants who die unexpectedly from misadventures such as road traffic accidents, drownings, etc.[5]

1.4. Legal and legislative framework

This Policy Directive is informed by the following NSW legislation, NSW Health policies, plan and framework:

- The *Coroner's Act 2009* (NSW)
- The *Children's Guardian Act 2019* (NSW)
- The *Health Records and Information Privacy Act 2002* [NSW] (HRIPA)
- The *Public Health Act 2010* (NSW) – Schedule 1 Medical conditions for reporting
- NSW Health Policy Directives:
  - *Coroners Cases and Coroners Act 2009* (PD2024_036)
  - *Health Care Records – Documentation and Management* (PD2025_035)
  - *Verification of death and medical certificate cause of death* (PD2023_014)
  - *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD2013_007)
  - *The Safety and Wellbeing of Children and Adolescents in NSW Acute Health Facilities* (PD2022_053)
  - *Incident Management* (PD2020_047)
  - *Investigation, Review and Reporting of Perinatal Deaths* (PD2022_046)
- NSW Health Guidelines:
  - *Recommended Safe Sleep Practices for Babies* (GL2021_013)
  - *Paediatric Service Capability (Paediatric Medicine and Surgery for Children)* [GL2024_005]

- Paediatric Improvement Collaborative *Clinical Practice Guideline:* *Death of a child: Sudden Unexpected Death in Infancy (SUDI)*
- Office of the Children's Guardian *Guide to the Child Safe Standards*
- The *NSW Health Child Safe Action Plan 2023-2027*
- The *NSW Aboriginal Health Plan 2024–2034*
- The *Integrated Trauma-Informed Care Framework: My story, my health, my future*

Further reference documents are listed in Section 8.

2. Clinical Governance

2.1. Incident notification within NSW Health

Note: Refer to Section 5.5 for information regarding notification of a sudden unexpected death in infancy (SUDI) to the NSW State Coroner and NSW Police Force.

2.1.1. Sudden unexpected death in infancy (SUDI) in the community

Where a sudden, unexpected death of an infant occurs in the community and the infant is brought to a NSW Health facility, notification in the NSW Health Incident Management System (ims+) is not required and the presentation is to be managed as a SUDI, as outlined in this Policy Directive.

2.1.2. Sudden unexpected death in infancy (SUDI) in the hospital

NSW Health staff must comply with NSW Health Policy Directive *Incident Management* (PD2020_047) and related local policies, whereby all deaths in hospital that are unrelated to the natural course of illness must be reported promptly in ims+. The NSW Ministry of Health must receive a Reportable Incident Brief (RIB) at MOH-RIBs@health.nsw.gov.au via +ims within 24 hours for RIB part A (basic information) and 72 hours for RIB Part B (further information).

2.2. Infant's eMR

Where a post-mortem is to be conducted under the direction of the NSW State Coroner (Coroner), the forensic pathologist (NSW Health Pathology) must have access to the infant's electronic medical record (eMR), **including a completed up-to-date medical history**. The eMR should be forwarded within 24 hours or by the next business day. For more information see Section 5.11 – Completion of the infant's medical history.

2.3. Case review

Local health districts (LHDs), specialty health networks (SHNs) and NSW Ambulance must have reporting processes in place that will enable review of all SUDI cases. This review may occur as a separate process, a death review (for NSW Ambulance) or as part of a mortality and morbidity meeting. SUDI cases less than 28 days of age are reported as per Perinatal

Death Reporting (PDR) requirements in the NSW Health Policy Directive *Investigation, Review and Reporting of Perinatal Deaths* (PD2022_046).

Where possible, other agencies and NSW Health organisations involved in management of the case should be invited, such as Forensic Medicine (NSW Health Pathology), NSW Ambulance and NSW Police. Forensic Medicine may also invite clinical staff to participate in a multi-disciplinary review (consider inviting LHD Child and Adolescent Safety Paediatrician (CASP) and/or Child Protection Paediatrician from a Child Protection Unit/Team).

If the baby was Aboriginal or the family has identified as Aboriginal, an Aboriginal Health professional with a designated cultural support role must be included in the case review to provide cultural advice.

2.4. Staff debrief

Experiencing a SUDI is a rare and distressing event for staff. Ideally, before the end of shift, a hot debrief (HDB) with emergency department staff and other staff immediately involved in the SUDI should be conducted, using the LHD/SHN preferred HDB tool. Hot debrief is a brief, interactive, structured team dialogue that takes place either immediately or very shortly after a clinical case. This debrief should be arranged by the senior nurse or midwife in charge but can be facilitated by any senior member of the emergency department team or ward team with appropriate experience/training.

NSW Ambulance staff should follow existing policies and procedures for debriefing staff.

The following support programs and resources are available for staff following a SUDI. LHDs/SHNs must ensure staff involved in a SUDI are aware of and have access to these supports.

- Nurse and Midwife Support 24/7 – national support service for Australian nurses and midwives.
- Nurse Midwife Health Program Australia – peer support counselling for nurses and midwives.
- Junior Medical Officer Support Program (1300 566 321)
- Employee Assistance Program (EAP)
- Clinical Excellence Commission (CEC) Reflective Practice – resources to assist staff in processing the challenges of high stress and high risk associated with healthcare.

Staff involved in a SUDI must be followed up by their respective clinical/managerial leads in the days following and actively encouraged to participate in longer term support if needed.

3. SUDI Case Manager

3.1. Role and appointment

The SUDI Case Manager role is to be added to the responsibilities of designated existing staff in each NSW Health hospital. In some cases, there might be several nominated personnel in a single facility who are designated with the SUDI Case Manager role.

SUDI Case Managers will be locally based members of staff, who have received education on sudden unexpected death in infancy (SUDI), cultural competence, trauma-informed care and child protection, and engage in continuous professional development and education on these topics.

The SUDI Case Manager will ideally be a social worker. In facilities where there is not a full-time social work team, this role may be allocated to another allied health role, or a nurse/midwife or health service manager. In very small facilities with limited staffing, the health service manager should take this role.

The SUDI Case Manager is called in as soon as the hospital is notified of a SUDI by the incoming ambulance. A SUDI is a rare event. Therefore, the role of SUDI Case Manager is included in the existing clinical role of one or more staff members.

As part of the implementation of this Policy Directive, local health districts (LHDs)/specialty health networks (SHNs) are to identify staff who are appropriate to perform the role of SUDI Case Manager and facilitate their professional development and education.

LHDs/SHNs are to have processes in place, tailored to the staffing profile of each facility, to ensure the availability of a SUDI Case Manager at any time. Remembering that the sudden unexpected death of an infant is a rare but significant event, LHDs/SHNs must ensure there are enough trained and available staff to cover in-person availability.

3.2. Operational responsibilities

The SUDI Case Manager coordinates and facilitates all steps for the SUDI process, focusing on:

- Ensuring staff have access to this Policy Directive.
- Supporting families during the examination of their baby and explaining the SUDI process, including where families have choice and where they do not (such as due to legislation) up to the handover to the Forensic Medicine Social Worker (See brochure: Initial Steps After a Death is Reported to the Coroner).
- Liaising with NSW Police Officers on-site with regards to supervision of the deceased infant.
- Assisting the family with practicalities, such as sitting with their baby, managing immediate needs, and accessing transport home.
- Offering chaplaincy support or contacting the family's priest/other religious support person, understanding that some families may wish for this support and others may not.
- Offering access to 24-hour support available through Red Nose.
- Considering the wellbeing of siblings and other children in the family.
- Informing the Department of Communities and Justice of the death where the infant is known to be in Out-Of-Home Care.
- Referring the family to the NSW Health Pathology Forensic Medicine Social Worker and providing a handover.

- Organising a follow up meeting to complete Stage 2 of the Medical History (remotely by local or networked paediatrician) or organising immediate collection of Stage 2 on-site (by on-site pediatrician or senior medical officer/visiting medical officer [VMO]) if the family prefers.
- Facilitating a cross-agency huddle before end of shift, with health service staff and cross-agency responders including NSW Ambulance and NSW Police. Taking action notes and distributing to agency members.
- Ensuring referral to a suitably qualified staff member (such as an LHD social worker) to follow up within 24 hours and ensure Stage 2 Medical History has been completed and family support commenced.

4. Family Centred Care

"We are so sorry for your loss"

Sudden unexpected death in infancy (SUDI) is a tragic event likely to create an intense response from the parents/carers and their families, as well as health professionals. As there is no 'appropriate' response to an overwhelming experience such as SUDI, behaviour of the parents/carers and their families may seem unusual. Staff should support and validate family responses to the death of their baby.

Parents/carers will forever remember what they see at this time and what was said to them. How they are communicated with, the words and the tone, the immediate care they received for them and their baby, and the support provided by health professionals can make a significant difference to parents/carers' and their families' grief.[7]

All interactions with parents/carers and other family members should be trauma-informed with a focus on the principles of trauma-informed care. These are:

- safety
- trustworthiness
- collaboration
- empowerment
- choice
- integration, and
- culture, history and identity.

Families should be offered access to chaplaincy support or contact with their religious support person.

The NSW Health *Integrated Trauma-Informed Care Framework* provides guidance for health care professionals providing support to families experiencing the sudden unexpected death of their baby.

4.1. Appropriate spaces for infant and family

Regardless of the NSW Health facility that the infant presents to, appropriate physical space that allows for quiet and privacy must be accessible. This space will enable discussions between parents/carers and staff, support management of the SUDI response, and allow families to spend time sitting quietly with their deceased baby.

4.2. Time with deceased infant

4.2.1. Providing a private and respectful space

While it may be necessary for a deceased infant to first be brought to the emergency department, as soon as is practical, the infant and parents/carers must be moved to an appropriate quiet, comfortable and private physical space within the health facility. Supervision by a health professional (usually the SUDI Case Manager) or NSW Police of the infant's body at all times is essential.

If an infant is clearly deceased and this has been confirmed by attending ambulance officers at the scene, the infant may be moved immediately to a private space.

Prior to the infant's body being transferred to Forensic Medicine (NSW Health Pathology), parents/carers may need to spend time sitting with their baby's body. Siblings and extended family members may also wish to spend time with the deceased baby and wherever possible, this must be enabled. This is particularly important for some cultural and religious groups.

4.2.2. Parent/carer support

From arrival to hospital and/or the time of death, no evidence relating to the possible cause of the infant's death is to be altered. The need for supervision must be explained carefully to parents/carers and must be undertaken in a manner that is sensitive to their grief and loss.

The parents/carers may hold their swaddled infant, however, it should be gently explained to them by NSW Health staff that handling of the infant's body should be careful so as to not affect any further investigations that need to be done. This includes washing their baby or removing anything from their baby's body, including cannulas, incisions, or dressings.

Parents/carers may express a desire to take hand/footprints and/or a lock of hair for memory making, however this cannot be done prior to the post-mortem. Parents/carers should be assured that hand/footprints and locks of hair can be taken with the Forensic Medicine social worker after the post-mortem if that is their wish.

Cultural and religious death rituals related to care of their baby's body should be accommodated as much as is possible, however any cultural/religious rituals involving the infant's body must be discussed with the Duty Pathologist (Forensic Medicine) and documented within the medical record.

See Section 5.7 – Care of the infant's body for further guidance.

4.3. Cultural safety for Aboriginal families

Aboriginal babies are overrepresented in SUDI [1]. Many Aboriginal people find hospitals difficult and traumatising places due to previous interactions or through the memories of their

elders. It is important that staff are aware of, and practice, trauma-informed care and that they support Aboriginal parents/carers in a culturally safe and respectful way.

Cultural safety in health care is defined by how health care is provided and how health care is experienced. The following steps should be taken to ensure culturally sensitive care and support for families:

- Offer access to an Aboriginal Health professional with a designated cultural support role so that Sorry Business can be supported on Country, along with other cultural requirements if requested by the family. Note that in most cases this access will be during business hours only and may be online.
- Ask about, and where possible accommodate, cultural practices in relation to death and kinship relationships.
- Ensure a quiet, private place is made available to parents/carers and space that can accommodate their extended family.
- Explain the SUDI process using culturally respectful language and checking for understanding, including talking about the post-mortem and limitations on handling of their baby's body.
- Provide culturally appropriate written materials, where available.
- Take a culturally respectful approach to gathering the infant's medical history, this includes:
    - Using culturally appropriate language when asking about previous illnesses and deaths in the family, and asking about child protection matters (if relevant).
    - Providing access to an interpreter if needed.
    - Asking about any cultural taboos, for example, the use of the baby's name or of other deceased relatives.
    - Limiting the use of medical terminology and using plain language.
- Check with Aboriginal families to see if they are feeling safe and their cultural needs are being met.

There are resources available specifically for staff to support Aboriginal people in culturally safe and trauma-informed practice, for example the Clinical Excellence Commission *Aboriginal Cultural Engagement during Open Disclosure Process*.

4.4. Culturally and linguistically diverse families

Staff must be sensitive to possible additional needs of multicultural, migrant and refugee families who are experiencing the sudden death of their baby. These may include:

- Ensuring access to an interpreter if needed.
- Offering access to religious or spiritual support.
- Making space for extended family.
- Support with cultural rituals to do with how death, post-mortems, and funerals are experienced and conducted.

4.5. Young families

As required under the *Children's Guardian Act 2019* (NSW), health services must provide care to children and young people under 18 years of age in alignment with the Child Safe Standards. This includes:

- Providing young families with opportunities to express their views and participate in decisions about care.
- Involving and informing young families' support networks (their families and relevant community supports) about care provision, where safe and appropriate to do so.
- Adapting care and communication to young families' diverse needs and abilities.

4.6. Infants in statutory Out-of-Home Care (OOHC)

NSW Health service staff should be aware that at the time of death of an infant in statutory Out-of-Home Care (OOHC), the parental responsibility role of the Minister for Community Services ceases, and parental rights revert to the infant's parents/guardians. However, the Department of Communities and Justice (DCJ) has responsibilities following the death, including notifying family and providing support to the birth and kinship/foster family.

Where the infant is known to be in OOHC, health professionals are to contact the DCJ via the Child Protection Helpline (24/7) or a Community Services Centre (CSC) known to be involved with the infant (during business hours) to advise them of the death.

This is permitted under the *Health Records and Information Privacy Act 2002* [NSW] (HRIPA) and ensures DCJ is able to promptly:

- Inform the birth family of the infant's death.
- Address the support needs of both the family of birth and the family caring for the child, including any other children in that family.
- Identify if there are siblings of the deceased child or young person and assess safety and risk for those children under their Sibling Safety Policy where this is appropriate.

DCJ (and/or the non-government organisation (NGO) with primary case responsibility for the child) will collaborate with the LHD/SHN and provide support to the affected families. Dependent upon circumstances, DCJ (and/or the NGO if applicable) will be a key contact in assisting NSW Health staff in working with the birth, kinship and/or foster family.

Wherever possible, the cultural and familial preferences of the infant's biological parents and family should be followed in the SUDI response.

4.7. Ongoing family support

NSW Health services should be aware of the long-term needs of families whose baby has died, including those providing foster and other forms of care, including kinship care. All families must be asked when they would like to be contacted for follow-up support.

Follow up with parents/carers and other involved family members by the LHD social worker must occur if indicated by referral from the Forensic Medicine Social Work team. This follow-up should assess the family's ongoing support needs, including access to Red Nose or other

grief support providers, as well as access to culturally appropriate support for Aboriginal families and those from culturally and linguistically diverse backgrounds. Families may benefit from proactive handover to support agencies.

In planning when and how follow-up support is offered, Aboriginal families must be asked about their cultural practices in relation to death and Sorry Business, as this might affect the timing of follow up.

Aboriginal Maternal and Infant Health services, including Aboriginal Community Controlled Health services should be part of the planning for ongoing support and be contacted if they are a current patient within these services to ensure community-based support and follow-up.

5. Management of Sudden Unexpected Death in Infancy (SUDI)

Sudden unexpected death in infancy (SUDI) will present in various ways, all of which require initiation of the SUDI response outlined in this Policy Directive. This includes unresponsive or deceased infants brought by their parents/carers or by NSW Ambulance, with or without NSW Police involvement. Infants may be pronounced deceased prior to arrival, on arrival to the emergency department (ED), or after admission. In some cases, infants may be transferred to a higher-level NSW Health hospital and then be pronounced deceased. Each of these presentations is considered a SUDI case and must be managed as outlined below.

Local health districts and specialty health networks must ensure that local policies guiding management of SUDI are easily accessible for staff. This includes EDs, maternity, paediatrics, intensive care and child and family health services.

All sudden unexpected deaths of infants, regardless of the circumstances, must be reported to the Coroner (see Section 5.5).

5.1. Cross-agency roles

The roles and responsibilities of each agency (NSW Health (NSW Ambulance and NSW Health Pathology), NSW Police, and the NSW State Coroner [Coroner]) are summarised at Section 6 – Roles and Responsibilities. A flowchart in Section 7.1 provides guidance for the SUDI response.

All facilities must have an up-to-date contact list in the ED of personnel specific to their location who should be contacted in the event of a SUDI. This list should include:

- the local health district (LHD)/specialty health network (SHN) on-call paediatrician
- the hospital social worker (or the on-call social worker if after hours)
- Aboriginal Health professional with a designated cultural support role
- on-call Forensic Medicine Clinical Nurse Consultant (CNC)
- the designated staff with SUDI Case Manager responsibilities
- the NSW Health Pathology Forensic Medicine social work team for their area
- the Child Abuse and Sexual Assault Clinical Advice Line (CASACAL)

- the Police Area Command (metro) or Police District (regional).

5.2. Record keeping

As with all episodes of patient care, where a SUDI case is managed in a NSW Health facility, accurate documentation in the health care record is required. For more information see NSW Health Policy Directive *Health Care Records – Documentation and Management* (PD2025_035).

Do not complete a Medical Certificate of Cause of Death – all SUDI deaths are reportable to the Coroner.

5.3. Sudden unexpected infant death in the community

The following steps outline the procedure for managing a SUDI in the community:

5.3.1. Immediate clinical actions

- Any infant that dies suddenly and unexpectedly in the community must be taken to their nearest ED.
- The designated SUDI Case Manager for the facility must be contacted as soon as the hospital is aware of a SUDI, which can be while the infant is in transit to the hospital.
- In the event the SUDI Case Manager is not available, a suitable staff member (such as the nurse or social worker) must be identified by the nurse-in-charge and allocated the role of coordinating immediate care of the parents/carers and relieved of other duties while doing so.
- On arrival, resuscitation will be attempted if immediate care can be provided as per usual ED practice and the ED senior medical officer and nurse-in-charge are notified of this infant's arrival. Local escalation policies must be followed where there is no on-site ED medical officer.
- If the infant is clearly deceased on arrival and no immediate care can be provided, the infant and family should be escorted to a quiet private space, away from the activity in the ED. The family time with their deceased baby must be supervised at all times.
- The ED senior medical officer is to verify the infant's death and let the parents/carers know. The infant must be registered as a patient in the ED.
- If attempted resuscitation occurred, any samples taken antemortem (for example, lumbar puncture or blood samples) must be submitted for testing as per normal clinical management of the cases. The remainder of the samples, following clinical testing, must be retained for provision to Forensic Medicine (NSW Health Pathology) if beneficial in determining cause of death. **No post-mortem samples are to be taken**.
- Where an infant is brought to a NSW Health facility without any contact with NSW Police, the ED senior medical officer or delegate must notify the Police Area Command (Metropolitan Commands) or Police District (Regional Commands) of the death of the infant.

5.3.2. Family support and cultural considerations

- The SUDI Case Manager is to coordinate immediate care of the parents/carers, including explaining the reason for the SUDI response and providing a quiet private space for them.
- If the deceased infant is Aboriginal or the family/carer identifies as Aboriginal, the hospital Aboriginal Liaison Officer or Aboriginal Health Worker (if available) should be notified. The family must be asked if they would like an Aboriginal Health professional with a designated cultural support role to be with them for non-clinical cultural support (if available). Not all families will want this option.
- If the preferred language of the family is not English, access to an interpreter must be arranged. Refer to NSW Health Policy Directive *Interpreters – Standard Procedures for Working with Health Care Interpreters* (PD2017_044).

5.3.3. Medical history and follow-up

- The infant's medical history must be completed by a senior health practitioner, using:
    - Stage 1 of the Medical History Template – SUDI (see Section 7.2). This should be the on-call paediatrician if available. If a paediatrician is not available on-site, the locally networked paediatric service or LHD/SHN Paediatric Head of Department should be contacted to determine who will complete the infant's medical history. Where no paediatrician is available, Stage 1 may be collected by the most senior ED medical officer on shift.
    - Stage 2 of the medical history can be collected by the networked paediatrician (virtual or in-person) on the next business day in a more suitable location for the family.
    - Forensic Medicine Clinical Nurse Consultants (CNCs) may provide educational guidance to the NSW Health clinical team prior to the medical history being taken, according to their availability and capacity, if required. Forensic Medicine CNCs are available only during office hours.
    - Families should be asked if they prefer the entire medical history to be taken immediately rather than having a follow-up interview for Stage 2 of the medical history. In this case, Stage 2 should be taken by the on-call paediatrician or the ED senior medical officer.
- If a medical risk to surviving siblings is indicated by the medical history or examination of the deceased infant, they should be admitted for observation. Refer to Section 5.10 for guidance on identifying and responding to child protection and wellbeing risk to surviving siblings.
- Where the infant's death occurs outside of business hours, and the LHD social work team is not available, the SUDI Case Manager must provide a handover to the relevant LHD social work team for the next business day. This may be by email.

5.4. Sudden unexpected infant death in hospital

The following steps outline the procedure for managing a SUDI within a NSW Health facility:

5.4.1. Immediate clinical actions

- Where a SUDI occurs in a NSW Health facility, the nurse or midwife-in-charge of the shift is to contact the SUDI Case Manager.
- In the event the SUDI Case Manager is not available, the nurse or midwife in charge must allocate a suitable staff member (such as a nurse, midwife or social worker) to the role of coordinating immediate care of the infant and the parents/carers and relieved of other duties while doing so.
- The infant's death is to be verified by the most senior medical officer available within the relevant department and the parents/carers informed.
- The senior medical officer or delegate must notify the Police Area Command (Metropolitan Commands) or Police District (Regional Commands) of the death of the infant.
- If attempted resuscitation occurred, any samples taken antemortem (for example, lumbar puncture or blood samples) must be submitted for testing as per the normal clinical management of the cases. The remainder of the samples, following clinical testing, must be retained for provision to Forensic Medicine (NSW Health Pathology) if beneficial in determining cause of death. **No post-mortem samples are to be taken**.

5.4.2. Family support and cultural considerations

- If the family identifies as Aboriginal, the hospital Aboriginal Liaison Officer or Aboriginal Health Worker (if available) should be notified. The family must be asked if they would like an Aboriginal Health professional with a designated cultural support role to be with them (if available) for non-clinical support, not all families will want this option.
- If the preferred language of the family is not English, access to an interpreter must be arranged. Refer to NSW Health Policy Directive *Interpreters – Standard Procedures for Working with Health Care Interpreters* (PD2017_044).

5.4.3. Medical history and follow-up

- The infant's medical history must be completed by a senior health practitioner using:
    - Stage 1 of the Medical History Template – SUDI (see Section 7.2). This should be the on-call paediatrician if available. If a paediatrician is not available, the locally networked paediatric service or LHD/SHN Paediatric Head of Department must be contacted to determine who will complete the infant's medical history. Where no paediatrician is available, Stage 1 may be collected by the most senior medical officer in the relevant department.
    - Stage 2 of the medical history is to be collected by the networked paediatrician (virtual or in-person) on the next business day in a more suitable location for the family.
    - Forensic Medicine Clinical Nurse Consultants (CNCs) may be available to provide educational support to NSW Health clinical team prior to the medical

history being taken, according to their availability and capacity. Forensic Medicine CNCs are only available during office hours.

- Families should be asked if they prefer the entire medical history to be taken immediately rather than having a follow-up interview for Stage 2 of the medical history. In this case, Stage 2 should be taken by the on-call paediatrician or the senior medical officer within the department.

- If a medical risk to surviving siblings is indicated by the medical history or examination of the deceased infant, they should be admitted for observation. Refer to Section 5.10 for guidance on identifying and responding to child protection and wellbeing risk to surviving siblings.
- Where the infant's death occurs outside of business hours, and the social work team is not available, a handover from the SUDI Case Manager to the relevant LHD social work team must be provided for the next business day. This can be by email.

5.5. Reporting a death to the NSW State Coroner

According to NSW Health Policy Directive *Coroners Cases and the Coroners Act 2009* (PD2024_036), sudden and unexpected deaths are reportable to the NSW State Coroner (Coroner). NSW Police must be notified of the death via the Police Area Command (Metropolitan Commands) or Police District (Regional Commands) so they can notify the Coroner.

Where any doubt exists as to whether a death should be reported, call the duty forensic pathologist or the clinical nurse consultant (CNC) at the relevant Forensic Medicine facility:

Business hours (8am - 4:30pm):

- Sydney (Lidcombe): 02 9563 9000
- Newcastle: 02 4041 4200.

After-hours:

After-hours calls should be directed to the Lidcombe Forensic Medicine facility. The relevant duty pathologist will be notified by the Lidcombe Forensic Medicine staff.

Where a death is reportable to the Coroner, a Medical Certificate of Cause of Death (MCCD) must not be issued. The Coroner's Checklist Verification of death (extinction of life) is to be documented in the *Report of a Death of a Patient to the Coroner (Form A)* (State Form SMR010.510). For more information see the NSW Health Policy Directives

- *Verification of death and medical certificate of Cause of death* (PD2023_014), and
- *Coroners Cases and Coroners Act 2009* (PD2024_036).

5.5.1. NSW Police act on behalf of the Coroner

Where an infant is brought to a NSW Health facility without any contact with NSW Police, Police must be notified of the death via the Police Area Command (Metropolitan Commands) or Police District (Regional Commands) so they can notify the Coroner. Police will liaise with the Department of Communities and Justice (DCJ) where required.

If the infant is brought to a NSW Health facility by NSW Police, the senior medical officer in charge of the shift or the nurse/midwife in charge must take a handover. This should include information on whether the death has been reported to the Coroner and whether the parents/carers have any objections to a post-mortem examination.

Once the infant's death has been confirmed, NSW Police, in their role representing the Coroner, are responsible for the care of the infant's body, timely transfer of the infant to the appropriate Forensic Medicine facility (after parents/carers have had time sitting with their baby) and investigation of the infant's death. NSW Police will organise formal identification of the infant, this is to occur before the infant's body leaves the hospital. If not possible at the hospital, Police will need to undertake formal identification at the Forensic Medicine Facility.

Where there is uncertainty or concerns about the roles and expectations of NSW Police in a NSW Health facility, the senior medical officer and nurse or midwife in charge should discuss their concerns with the most senior attending NSW Police officer. Any ongoing concerns should be escalated via the hospital executive and the Police Area Command or Police District.

5.6. Notifying Forensic Medicine (NSW Health Pathology)

Once NSW Police have been notified, the senior medical officer must inform the duty forensic pathologist or CNC at the relevant Forensic Medicine facility of the SUDI death. Ideally this should be the senior medical officer who completes Stage 1 of the infant's medical history. The senior medical officer may also use this contact to seek advice if needed. After-hours calls should be directed to the Lidcombe Forensic Medicine facility.

Once Forensic Medicine has been notified, the SUDI Case Manager must make a referral to the Forensic Medicine social worker for the infant's parents/carers and/or foster or kinship carers (if infant was in Out-of-Home Care [OOHC]) via phone or email. This should include the name and contact details of the paediatrician and/or other clinical staff e.g. social worker, involved with the SUDI.

Forensic Medicine must also be informed of any existing pathology samples taken prior to death, such as blood and urine, as these samples may be required for further testing as part of the coronial investigation. Contact details for Forensic Medicine are in Section 5.5.

5.7. Care of the infant's body

While transporting the deceased infant to hospital by ambulance, the infant may be loosely swaddled in a blanket. The infant should not be tightly wrapped. Parents can hold the baby during transport.

According to NSW Health Policy Directive *Coroners Cases and the Coroners Act 2009* (PD2024_036) the hospital whose care the infant's body is in, is responsible for the safe custody of the body until it is removed by NSW Police. This implies that the infant's body will be in the same condition as when the death occurred and includes no interference with cannulas, incisions or dressings.

All contact with the infant's body must be supervised by NSW Police or a health professional. From arrival to hospital and/or the time of death, no evidence relating to the possible cause of the infant's death is to be altered. However, parents/carers may stay with their infant, under

supervision, and with support of the SUDI Case Manager. The parents/carers may hold their swaddled infant, however, it should be gently explained to them by NSW Health staff that handling of the infant's body should be careful so as to not affect any further investigations that need to be done. This includes washing their baby or removing anything from their baby's body, including cannulas, incisions, or dressings.

The parents/carers will be able to see their infant again after the post-mortem examination has taken place.

As much as possible, cultural and religious death rituals should be accommodated. The SUDI Case Manager should contact the on-call Forensic Pathologist if unsure. Any such rituals must be recorded in the infant's medical record and/or any additional notes provided to Forensic Medicine.

Parents/carers may express a desire to take hand/footprints and/or a lock of hair for memory making, however this cannot be done prior to the post-mortem. Parents/carers must be assured that hand/footprints and locks of hair can be taken with the Forensic Medicine social worker after the post-mortem if that is their wish.

5.8. Initial care of the parents/carers

The SUDI Case Manager is to coordinate care of the parents/carers, including:

- explaining the SUDI process
- organising a private space for discussions
- access to toilets and refreshments
- introductions to staff members
- contacting family/friends
- access to any services they may need immediately, such as interpreter services, hospital-based Aboriginal Liaison Officer or Aboriginal Health Worker and religious/cultural organisations
- asking the parents/carers if they would like support from the hospital/health service's pastoral care/chaplaincy service (or equivalent) where appropriate/available.

Where parents/carers require medical review, such as lactation advice or referral to mental health services, this must be discussed with the senior medical officer overseeing the SUDI response. See also NSW Health information on "Breast care when your baby has died".

"We want to help you understand why your baby died"

On arrival at hospital parents/carers are to be informed of each step in the process, using terminology they can understand, and be given the opportunity to ask questions, including that:

- The circumstances of the infant's death means that the death is reportable under the *Coroners Act 2009* (NSW). Therefore, any contact with the infant must be supervised by a health professional or NSW Police at all times.

- Although they are not able to take hand/footprints and locks of hair at this time, they can request that hand/footprints and locks of hair are taken with the Forensic Medicine social worker after the post-mortem.
- A comprehensive medical history of the infant and family members will be taken, initially while the infant's body is in hospital, and then in a follow-up interview within 24 hours in a quiet location to assist with establishing the cause of death.
- NSW Police, in their role representing the Coroner, will likely ask questions about the circumstances of the infant's death and request that a next of kin formally identifies the infant's body.
- NSW Police will explain the coronial process and provide them with a copy of the Initial steps after a death is reported to the Coroner brochure. Information provided should include:
    - That the purpose of the post-mortem examination is to establish the cause of death.
    - That the results of the post-mortem may benefit surviving family members, including siblings, for example, by identifying any genetic diseases.
    - Details of where the post-mortem will occur.
- Parents/carers have a right to either agree to or object to a post-mortem. The implications of either option should be discussed.
- The Coroner must be notified of objections to the post-mortem. If the parents/carers decide to object to the post-mortem:
    - NSW Health staff must inform NSW Police. The objection to the post-mortem must be recorded in the infant's health care record.
    - Assistance in exploring the objection must be offered, with further information available from the social worker at the relevant Forensic Medicine facility.
    - A representative from the Coronial Information and Support Program will contact the parents/carers to discuss the objection and post-mortem.
- The Forensic Medicine social worker will contact the parents/carers the next business day after the infant's body is admitted to the Forensic Medicine facility. Information and support about the coronial process and viewing of the infant's body can then be discussed.
- A representative from the Coronial Information and Support Program may contact the parents/carers following the post-mortem to discuss any organ retention.
- A Forensic Medicine social worker will contact the parents/carers to discuss the interim post-mortem results and next steps.

5.9. Initial care of siblings

It is particularly difficult for siblings and staff when siblings of the infant have witnessed the death, discovery or resuscitation attempts. The assessment and care of surviving siblings, who may also present to the hospital with the parents/carers, is an important part of care.

LHD/SHN social workers should be able to provide resources and referrals to services that can provide support for siblings experiencing grief and loss, such as Red Nose. A proactive referral may be more effective than a brochure.

5.10. Child protection and wellbeing

A SUDI, in and of itself, does not automatically give rise to child protection concerns for siblings. However, there are circumstances in which a SUDI or surrounding circumstances may give rise to child protection or wellbeing concerns for children, including those not physically present.

Consideration must be given to the safety and care of any other children for which the parents/carers are responsible. To support an assessment of the safety of surviving siblings, identify appropriate clinical responses (including admissions) and inform any child protection reports, specialist medical and forensic advice must be sought where:

- there are concerns that the SUDI may have been the result of a non-accidental injury or neglect, or
- there are no concerns that the SUDI may have resulted from non-accidental injury or neglect, but other psychosocial child protection risk factors for the family have been identified.

Health professionals located in facilities with tertiary child protection services may contact the Child Protection Unit/Team directly for advice. All other health professionals should contact the 24/7 Child Abuse and Sexual Assault Clinical Advice Line (CASACAL) on **1800 244 531**.

If safety, welfare or wellbeing concerns for surviving siblings are identified, NSW Health staff must follow the NSW Health Policy Directive *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (PD2013_007) and:

- make a suspected Risk of Significant Harm (ROSH) report to the Child Protection Helpline where there are immediate significant concerns, OR
- where there are current but not immediate concerns for siblings, contact the NSW Health Child Wellbeing Unit during business hours for advice on next steps.

Other resources available are:

- LHD/SHN Child and Adolescent Safety Paediatrician (where available)
- Department of Communities and Justice (DCJ) NSW Mandatory Reporter Guide
- Child Protection Helpline 132 111 (DCJ)
- NSW Health Child Wellbeing Unit 1300 480 420 (Monday to Friday 8:30am - 5pm).

5.11. Completion of the infant's medical history

The Medical History Template – SUDI (Section 7.2) includes details about the infant's health, parents/carers and events in the hours leading up to the infant's death, including the exact position the infant was found and the response of the parents/carers. Some questions may seem intrusive, however, they relate to known risks for infant mortality and may assist with establishing the cause of death.

When talking to parents/carers about other children in the family, it is important to let families know that the purpose of the questions is to make sure that other children in the household are safe and well. Some families may benefit from reassurance that a SUDI, in and of itself, will not automatically result in a report to child protection services.

Where possible, information provided by the parents/carers should be recorded using their exact words. Parents/carers must be given the opportunity to ask questions and discuss any concerns that they have.

Medical history information is collected in 2 interviews, unless parents/carers prefer to complete it in a single interview in the hospital at the time their deceased infant is brought in.

The 2-stage interview is intended to reduce the stress for parents/carers who are dealing with the immediate loss of their infant while balancing the need to gather a timely and comprehensive medical history to help determine the cause of death. Stage 2 can be done via telehealth or other virtual means, as long as a support person is physically with the parents/carers/family for the interview.

Inclusion of NSW Police when taking medical history

If NSW Police are included as observers during the medical history discussion, roles must be clarified before the discussion begins. Parents/carers should be reassured that NSW Police presence does not indicate an assumption of implication in the death of the infant.

Details of those present during the discussion must be documented in the health care record.

5.11.1. Stage 1: Immediate essential information

Immediate essential information is collected in the emergency department (ED) at the time the infant is brought in, by a senior health professional, such as the on-call paediatrician or ED physician. This information is needed to:

- establish the infant's identity
- commence or add to the infant's health care record
- understand any immediate events (such as any illness, medications administered in the last 24 to 48 hours)
- record any treatment or resuscitation attempts
- confirm the infant's death
- identify if there have been other sudden deaths in the family
- identify whether there are any other children in the family, and if so, their ages and whether any safety, welfare or wellbeing concerns are held for those children.

At this stage, any information recorded by NSW Police or NSW Ambulance can be provided to NSW Health staff to be added to the infant's medical record.

At this point, parents/carers can be asked if they would prefer to provide the entire medical history now, or to take part in a second interview to collect the remaining medical history, on or before the next business day, in their preferred location, including online. If there are concerns regarding a possible non-accidental death, NSW Health staff should confer with the

Senior Investigating Officer, NSW Police, prior to any offer to delay obtaining health information.

5.11.2. Stage 2: Extended medical history

Parents/carers prefer entire medical history to be taken immediately

If parents/carers inform the SUDI Case Manager that they choose to complete the medical history in a single interview at the time of their infant's presentation to the hospital, the SUDI Case Manager should alert the regional on-call or on-site paediatrician or the relevant senior medical officer. The paediatrician or senior medical officer should then take Stage 2 of the extended medical history in a quiet, suitably private location in the hospital.

Parents/carers prefer extended medical history to be taken later

Before parents/carers leave the hospital, the SUDI Case Manager must arrange a follow-up meeting to complete Stage 2 of the extended medical history. This interview is to occur on or before the next business day, in a location convenient for the family (such as a quiet room at the hospital, community health centre, or their home) or via telehealth, provided a support person is physically present.

The 2-Stage Medical History Template – SUDI is in Section 7.2. Where possible, the paediatrician should prepopulate the history with available data to minimise unnecessary duplication of questions, noting some duplication may be necessary if prior information is incomplete or collected for a different purpose.

The Case Manager must:

- Ensure at least one suitably qualified clinician is available to commence the medical history and complete Stage 1 before discharge.
- Coordinate completion of Stage 2 by the networked paediatrician, with educational support from the Forensic Medicine CNC prior to the interview if required.
- Organise a culturally appropriate support person (such as an LHD social worker, Aboriginal Health professional with a designated cultural support role, culturally and linguistically diverse support worker) to attend in person. This person does not have a clinical role.
- Confirm that any missing information from health care records, NSW Police (Form P79A), or NSW Ambulance is obtained and documented.
- Ensure the additional essential information required by Forensic Medicine is provided on the next business day.

5.11.3. Incomplete medical history

In some cases, despite the best efforts of NSW Health staff, parents/carers may be too distressed to accurately provide a full medical history by the first business day after the death of an infant. The medical history must still be provided to Forensic Medicine on the next business day, with an explanatory note as to why it is incomplete.

If on receipt of an incomplete medical history, the need for additional information is identified, Forensic Medicine is to contact the senior medical officer who completed the infant's medical history. If the senior medical officer is not able to be contacted, the Director of Medical Services/Administration of the hospital or facility should be contacted.

5.11.4. If sudden unexpected death in infancy (SUDI) occurs on a weekend

In cases where an infant death occurs after working hours on a Friday through to Sunday, the Stage 2 extended medical history can be taken on the next business day, usually the Monday immediately following, and provided to Forensic Medicine.

Post-mortem examinations do not occur over extended public holidays, however, the medical history can be received at any time over the public holiday, so that the documents are ready for triage by the duty pathologist on the first working day following the long weekend.

5.11.5. Screening for metabolic and genetic diseases

When taking Stage 2 of the extended medical history, the networked paediatrician should consider any conditions that may have implications for surviving family members. Features of possible genetic problems include a **history of sudden, unexpected death in family members**, including recurrent syncope, epilepsy and drowning. If there are concerns, the networked paediatrician should discuss genetic testing with the infant's biological parents and, if appropriate, make a referral to the relevant LHD/SHN Genetics Clinic.

There may be circumstances where genetic/familial medical history is inaccessible, for example, in cases involving adoptive parents and parents who have utilised egg and/or sperm donation and/or surrogacy services. Clinicians should be sensitive to this possibility when discussing genetic or familial health issues with parents/carers.

As the infant's death is reportable to the Coroner, no samples of any kind can be taken after death without the permission of the Coroner. If there is a request for peri-mortem specimen collection, call the forensic pathologist at the relevant Forensic Medicine facility. For contact details see Section 5.5.

5.12. Advising parents/carers' primary care service

Parents/carers must be asked if they attend a regular primary care service, including a general practice (GP), or an Aboriginal Community Controlled Health Service (ACCHO).

If so, the networked paediatrician should contact the primary care service, with the parents/carers consent, to:

- Inform them of the infant's death.
- Discuss any relevant information about the infant and the parents/carers.
- Discuss investigations required, for example, an ECG on the infant's biological parents and genetic siblings (if indicated).
- Discuss advice provided about lactation.
- Offer assistance with support and referral for the infant's parents/carers.

5.13. Transfer to Forensic Medicine (NSW Health Pathology)

Once parents/carers have had the opportunity to spend time with their infant and Stage 1 of the infant's medical history is complete, NSW Police will arrange for the infant's body to be transferred to the appropriate Forensic Medicine facility. This should occur as soon as possible, as extended delays can impact the post-mortem examination and therefore timing of the report.

NSW Police arrange transfer of the infant's body via a government contractor, there is no cost for the transfer.

5.13.1. Forensic Medicine social worker

The SUDI Case Manager must provide a handover to the Forensic Medicine social work team where the post-mortem will occur. This should include the contact details of the paediatrician and/or social worker who was involved in the initial SUDI response. This enables an effective transfer of care of the infant back to the local health facility, if required, when the Forensic Medicine social worker's role is completed.

Contact details of the Forensic Medicine social work team should be given to the parents/carers prior to transfer of the infant's body.

The Forensic Medicine social worker team will:

- Accept a handover from the SUDI Case Manager (usually by email).
- Contact the parents/carers to confirm that the infant's body has been admitted to the facility (the next business day).

The Forensic Medicine social work team is available during office hours (8:00am to 4:30pm) at all sites. After hours, social work service is available as follows:

- Sydney: 6pm to 10pm on weekdays, 8am to 8pm on Saturdays and Sundays
- Newcastle: 1pm to 5pm on Saturdays and Sundays
- Wollongong: no after-hours social work support is available. However, the Wollongong Hospital social work team may accommodate requests for viewings after-hours.

While the coronial process is ongoing, up until after the final post-mortem report has been discussed, parents/carers who have experienced the sudden unexpected death of an infant can access immediate and ongoing support, advice and referral to other services from the Forensic Medicine social work team.

5.13.2. Infant's eMR provided to Forensic Medicine

According to NSW Health Policy Directive *Coroners Cases and Coroners Act 2009* (PD2024_036), where a post-mortem is to be conducted under the direction of the Coroner, the forensic pathologist must have access to a copy of the infant's electronic medical record (eMR) as soon as possible.

Admission documentation, the infant's completed medical history, the NSW Ambulance clinical record, records of any medications given, and the infant's growth charts should be

sent to Forensic Medicine as part of the infant's medical record. These records should be sent to Forensic Medicine **on the next business day after the death of the infant**.

The hospital is responsible for providing a copy of the eMR to the Coroner. Release of copies of medical records should be handled by the medical records department (however named) or their delegate.

The eMR may be sent with the infant's body, if the Stage 2 extended medical history has been fully completed, but should be collated, packaged and forwarded in a sealed envelope.

Following transfer to Forensic Medicine

Agencies that request a copy of the infant's medical record, including Forensic Medicine and NSW Police, after the infant's body has been transferred to Forensic Medicine, must be referred to the hospital's medical records department. If the infant's medical record is not received by Forensic Medicine on the next business day after the infant's death, Forensic Medicine are to contact the hospital's medical record department.

Where a copy of the infant's medical history has not been received or further information is required, Forensic Medicine is to contact the senior medical officer who completed the infant's medical history. If the senior medical officer is not able to be contacted, the Director of Medical Services/Administration of the hospital or facility should be contacted.

5.14. Parents/carers departure from hospital or health care facility

Before parents/carers leave the hospital or health care facility, the SUDI Case Manager must confirm any appointments made, including the time and place of the collection of Stage 2 of the medical history. SUDI Case Managers are to also discuss the notification of other health professionals previously involved in the infant's care with the parents/carers.

Parents/carers may want to nominate a family member to act as a contact to assist with decision making on their behalf.

Information, both written and verbal, about how to access further support and advice should also be provided by the SUDI Case Manager, such as:

- child and family health services
- their local GP
- a medical specialist
- mental health services
- services for Aboriginal families, such as the Aboriginal Maternal and Infant Health Service (AMIHS) or Building Strong Foundations (BSF)
- NSW Refugee Health Service
- Red Nose Grief and Loss (24/7 support).

The SUDI Case Manager must offer practical assistance and advice to parents/carers including arranging transport home, care of siblings and funeral arrangements. Parents/carers should not set a date for their infant's funeral until they have made contact

with the Forensic Medicine social worker. For after hours or immediate support parents/carers should be encouraged to contact Red Nose Grief and Loss for 24/7 telephone grief support.

5.15. Cross-agency huddle

Before the shift ends and after parents/carers have left the facility, the SUDI Case Manager must facilitate a cross-agency huddle. All cross-agency responders, including NSW Police and NSW Ambulance, should be invited to attend. Whenever possible, Aboriginal representation should be included if the family is Aboriginal. Some agency personnel may need to attend virtually due to other demands. The huddle must discuss the actions taken in regard to the SUDI, including:

- any cultural and religious considerations for the family
- any additional work that needs to be done and by whom
- plans for the follow-up in the next 24 hours
- any issues that arose during the SUDI event.

The SUDI Case Manager or a delegate must take action notes from the meeting and circulate them to all agency team members, so that there is a shared understanding of the outcomes of the huddle. A suggested template for the huddle notes is shown in Section 7.4.

5.16. The post-mortem examination

A post-mortem (or autopsy) is a detailed examination of a body by a pathologist who has training in this field. A post-mortem is requested by the Coroner to inform a balanced, accurate finding regarding the cause of death. In NSW, all post-mortem examinations after a SUDI death are undertaken at one of the 3 Forensic Medicine facilities, in Sydney, Wollongong or Newcastle.

As per Section 5.8, the Forensic Medicine social worker will contact the parents/carers to discuss the interim post-mortem results and next steps. The Forensic Medicine social worker will also:

- If requested, arrange for hand/footprints and locks of hair to be taken.
- Facilitate viewings of the infant's body after the post-mortem.
- Ask if the parents/carers would like to be contacted by a Forensic Medicine social worker when the final post-mortem report is available to discuss.
- Confirm that the infant's body can be released to the funeral director.

If organ retention occurred as part of the post-mortem, the parents/carers will be contacted by a representative from the Coronial Information and Support Program to discuss approval by the Coroner, release, retention timeframes and options for disposal or return of organs.

Forensic Medicine does not release any of the reports generated to My Health Records. Images and diagnostic imaging reports are retained in Forensic Medicine as part of the Coronial file.

5.16.1. Final post-mortem examination report

Once the final post-mortem report is complete, the Coroner will notify the parents/carers via a letter. Parents/carers can request a copy of the final post-mortem report by submitting a written request to the Coroner, which may be sent via email. There is no charge to parents/carers for a copy of the report. Some of the tests undertaken are complex so it may take months for the post-mortem report to be available. It is not uncommon for the cause of death to be unascertained.

Requests for a copy of the post-mortem report from NSW Health to the Coroner must be made in writing from the hospital's Director of Medical Services (DMS) or Director of Clinical Governance (DCG) directly to the Coroner. If the clinician overseeing care of the infant and family would like a copy of the post-mortem report, they should contact their DMS or DCG.

Once the final post-mortem report is available, if parents/carers agreed to be contacted, the Forensic Medicine social worker will contact the parents/carers and offer to discuss the report. The Forensic Medicine social worker can also assist parents/carers with requesting a copy of the post-mortem report from the Coroner.

Parents/carers can discuss the post-mortem report with the Forensic Medicine social worker and the forensic pathologist. Parents/carers can also discuss the report with the hospital social worker, senior medical officer, paediatrician or general practitioner involved in their infant's care.

Where there are unanswered questions about the post-mortem report, parents/carers or clinical staff can contact the Forensic Medicine social work team at the relevant Forensic Medicine facility for further discussion. The Forensic Medicine social work team will facilitate any discussion with the forensic pathologist.

During discussions about the final post-mortem report, any referrals (including a referral back to the LHD/SHN social work team if needed) or further support required by parents/carers are to be provided.

6. Roles and Responsibilities

Response to Sudden Unexpected Death in Infancy (SUDI) - Roles and Responsibilities	
Role	**Responsibilities**
NSW Ambulance	• NSW Ambulance to attend, assess, attempt resuscitation (if indicated) and transport infant to hospital. • Complete an Ambulance Clinical Record and handover.
NSW Police	• Attend scene. • Explain coronial process, provide Initial steps after a death is reported to the Coroner brochure. • May supervise parents/carers' interactions with the infant's body. • Interview parents/carers and complete NSW Police Form P79A.

	• Ensure any objection to the post-mortem is documented. • Liaise with Department of Communities and Justice (DCJ). • Complete formal identification of the infant's body. • Coordinate transfer of the infant's body from the hospital to Forensic Medicine (NSW Health Pathology). • Preserve and examine scene (Forensic Services, NSW Police). • Seize and retain any relevant exhibits that will not be transported to the Forensic Medicine Facility with the infant's body.
SUDI Case Manager	• Inform parents/carers of SUDI process. • Support parents/carers in spending time with infant (under health profession supervision). • Organise practical support, including a private space, refreshments, and assistance from extended family, religious, cultural and Aboriginal support services and access to an interpreter. • Offer contact with Red Nose Grief and Loss. • Coordinate access to lactation support and/or referral, where required. • Provide handover to Forensic Medicine CNC, if required. • Provide handover to Forensic Medicine social work team. • Provide handover to hospital/LHD/SHN social work team. • Facilitate cross-agency huddle. • Organise logistics for taking Stage 2 of the infant's medical history on next business day, ensuring involvement of local support.
Nurse/Midwife in charge	• Coordinate nursing/midwifery care. • Contact SUDI Case Manager and Paediatrician. • Liaise with SUDI Case Manager about care of parents/carers. • Coordinate staff debrief.
Senior emergency department medical officer (ED MO) or admitting medical officer (AMO) or Senior Medical Officer for the department	• Manage medical care, including verifying the infant's death (extinction of life). • Contact NSW Police if they have not yet been contacted • Contribute to completion of Stage 1 of the infant's medical history. • Coordinate ongoing medical care of parents/carers, including documentation and referrals.
Paediatrician/ Senior Medical Officer	• Undertake paediatric medical examination and complete Stage 1 of medical history.

	• Consider whether the infant's death is medical or due to non-accidental injury or neglect. If indicated:
	  ○ seek advice from Child Protection Unit or CASACAL, and
	  ○ discuss concerns with NSW Police and/or Coroner.
	• Consider safety and well-being of other children in the family.

Paediatrician (may be networked)	• Take infant's medical history and documentation (Stage 2), if requested and if resources allow. • Contact general practitioner (GP) • Participate in Forensic Medicine (NSW Health Pathology) multi-disciplinary meeting, if required.
LHD/SHN Social Worker	• May take on role of SUDI Case Manager. • Accepts referral from SUDI Case Manager and follows up family immediately after a SUDI to ensure they are linked into available supports. • May accept a referral from the Forensic Medicine Social Worker after the post-mortem report is completed.
Aboriginal Health professional with a designated cultural support role (if requested)	• If families request support, work with the SUDI Case Manager to provide culturally safe non-clinical support to parents, carers and families that identify as Aboriginal or if the baby is Aboriginal. • Provide cultural advice in any case review or care coordination meetings about the SUDI or support for the family
Forensic Medicine (NSW Health Pathology)	• Forensic Medicine Clinical Nurse Consultants (CNCs) provide educational support and guidance to paediatricians (if required) prior to the SUDI medical history taking, subject to their availability. • Forensic Medicine Pathologist completes post-mortem examination. • Forensic Medicine social worker offers parents/carers support, advice and referral. • Forensic Medicine social worker and pathologist offer to discuss post-mortem results with parents/carers. • Coordinates multi-disciplinary case review.
General practitioner (GP)	• Provide information to the networked paediatrician about the infant and parents/carers where required. • Organise electrocardiogram (ECG) for biological parents and siblings, if indicated. • Provide ongoing support and referral for parents/carers.
Medical records/clerical	• Forward copy of infant's medical record to Forensic Medicine on next business day.

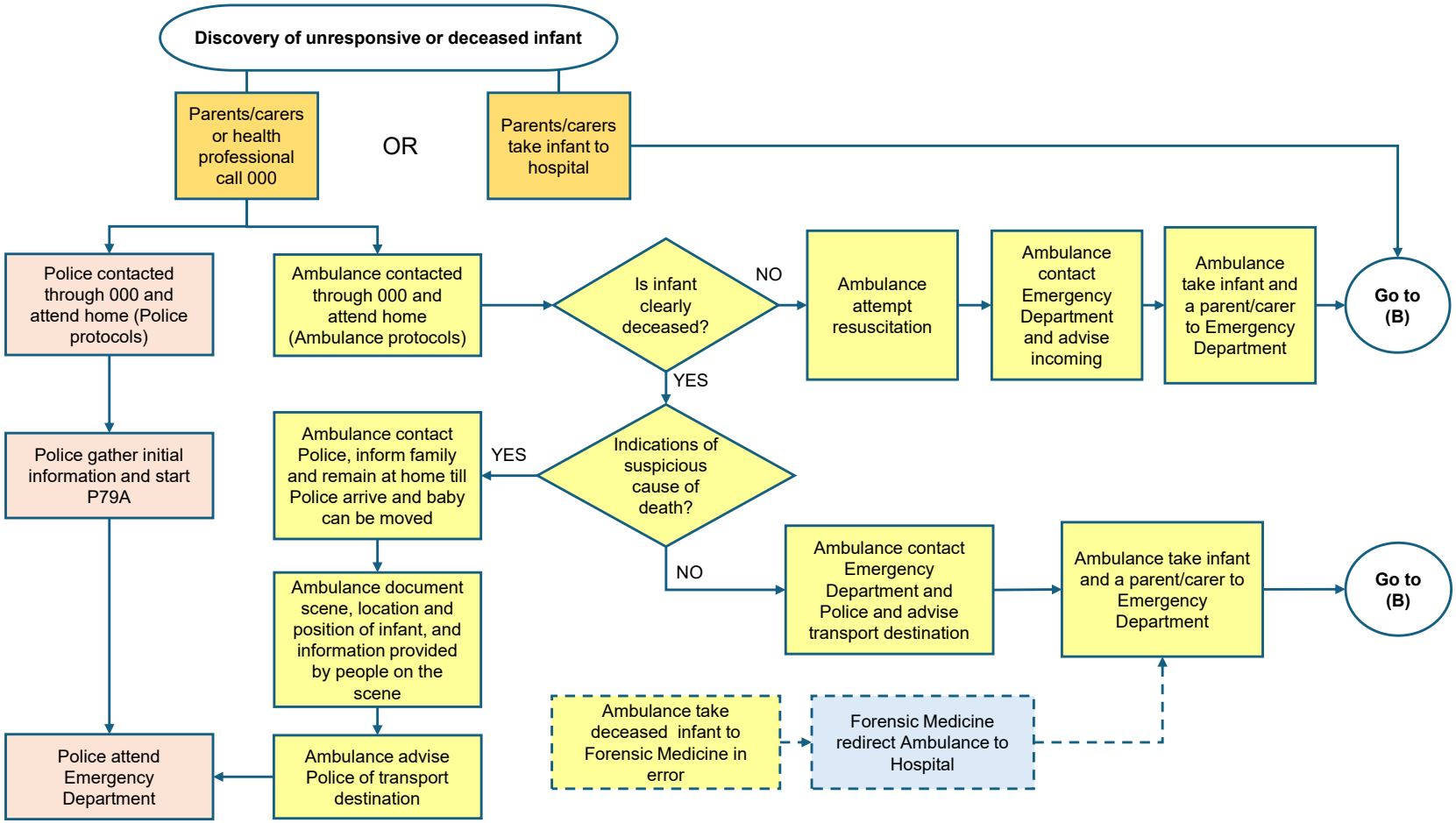
NSW State Coroner	• Determine manner and cause of death and need for inquest based on post-mortem report and police investigation. • Consider requests for release of post-mortem report.
Director Clinical Governance/ Director Medical Services	• Manage requests for post-mortem report. • Distribute post-mortem report to relevant clinicians.

7. Appendices

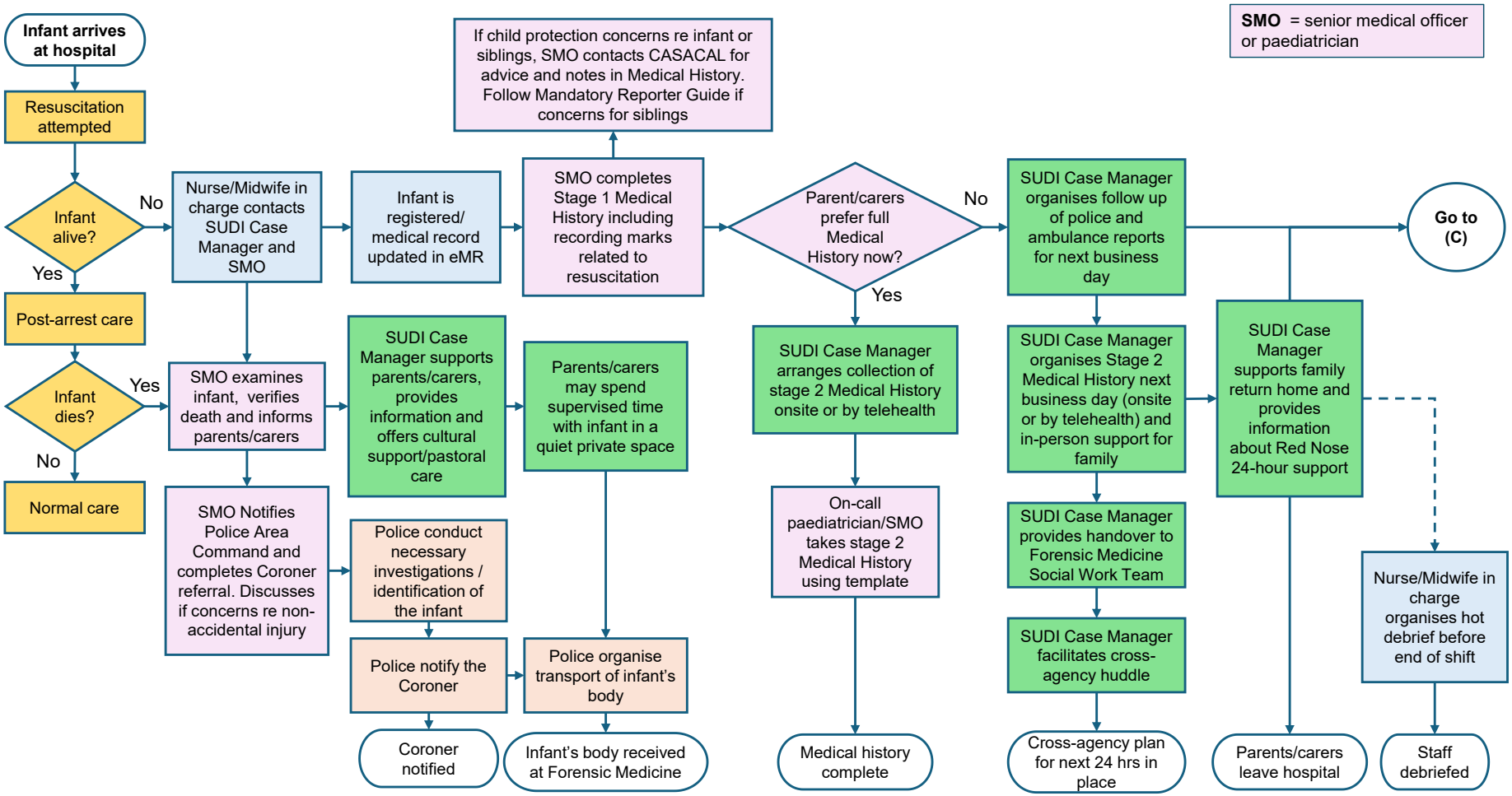
1. SUDI Response Flowcharts
2. Medical History Template – SUDI
3. SUDI Checklist – before end of shift
4. Cross-agency Huddle – Template
5. SUDI Contact List

7.1. SUDI Response Flowcharts

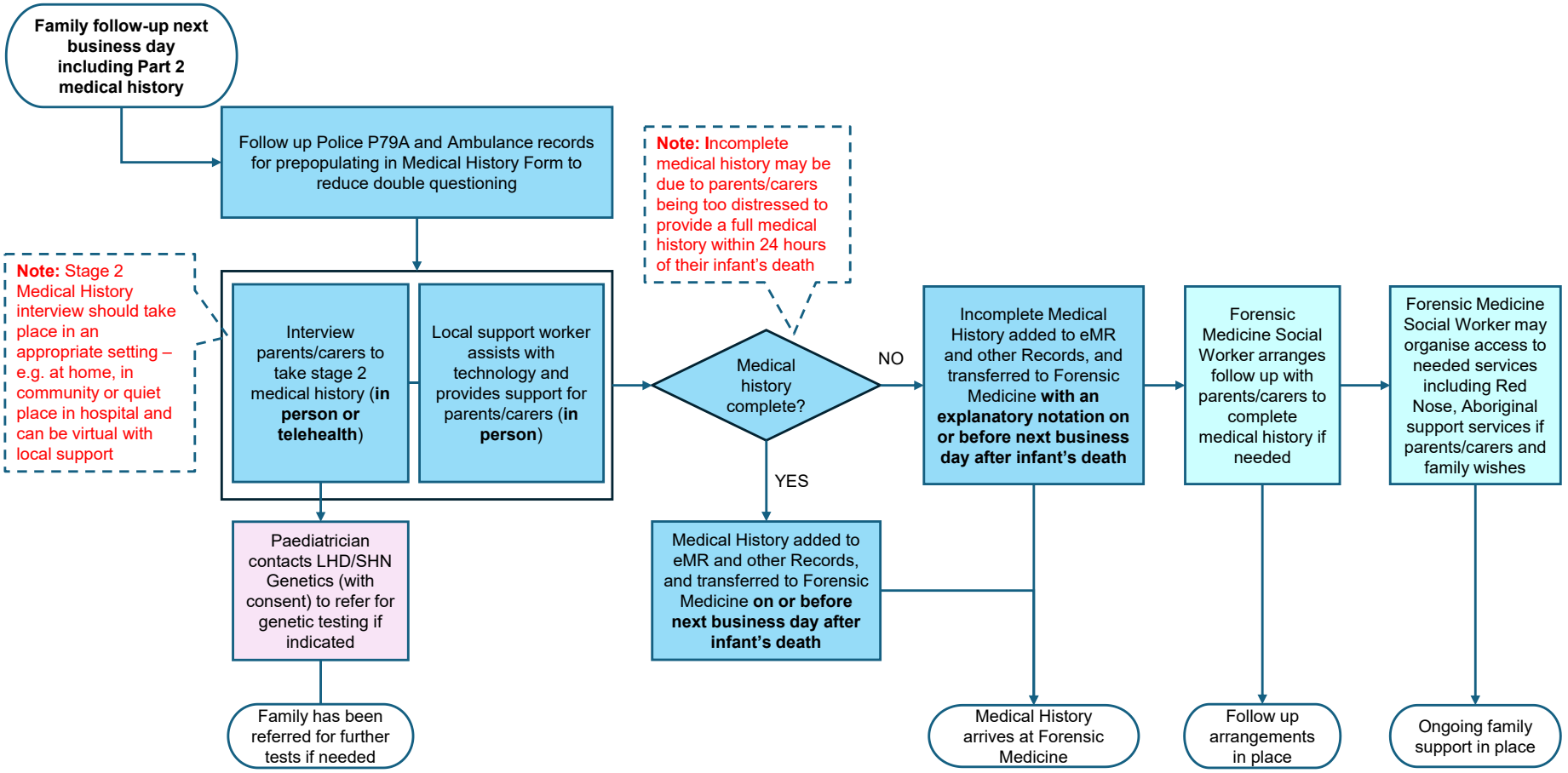
7.1.1. A. Initial response in the community



7.1.2. B. Immediate response in the emergency department



7.1.3. C. Next business day



7.2. Medical History Template – SUDI

The infant's medical history must be completed by a senior health practitioner, using:

Stage 1 of the Medical History: This should be the on-call paediatrician or the senior medical officer from the relevant department. If a paediatrician is not available, the locally networked paediatric service or LHD/SHN Paediatric Head of Department should be contacted to determine who will complete the infant's medical history.

Stage 2 of the medical history: This can be collected by the networked paediatrician on the next business day in a more suitable location for the family. Support may be requested from the Forensic Medicine CNC, who may provide advice ahead of the Stage 2 interview.

Clinicians can undertake the Stage 2 interview remotely as long as a suitably qualified on-site staff member is physically with the family in a non-clinical role to provide support and assistance. Families should be asked if they prefer the entire medical history to be taken immediately rather than having a follow-up interview for Stage 2 of the medical history.

7.2.1. Stage 1 – Immediate information collected when infant is brought to hospital

This information should be routinely collected as part of the establishment/update of the infant's medical record and should include any treatment provided (such as resuscitation attempts) and confirmation of the infant's death (extinction of life). It is also important to ascertain any issues regarding immediate medical or other risks to immediate family members, including other children in the household.

Section completed by	Question	Response
Identification of infant		
Name: Contact:	Infant's name	
	Date of birth	
	Date of death	
	Sex M/F	
	Infant ethnicity/Aboriginal/Torres Strait Islander	
	Parent/carer ethnicity/Aboriginal/Torres Strait Islander	
	Address of infant	
	Is infant in Out-of-Home Care (including relative/kinship care, foster care)?	
	Is infant from a multiple birth?	

Section completed by	Question	Response
	(specifically, a living twin, triplet or other multiple birth sibling)	
	Name of parent/carer 1	
	Relationship to infant	
	Foster/kinship carer?	
	Address (if different to infant's)	
	Contact details	
	Name of parent/carer 2	
	Relationship to infant	
	Address (if different to infant's)	
	Contact details	
Resuscitation / treatment / examination of infant		
Name: Contact:	Resuscitation attempted?	
	Where?	
	Who by?	
	Marks on infant related to resuscitation / treatment by NSW Ambulance or in emergency department (ED) (Use a body diagram to map marks)	
	Antemortem samples collected during and as part of treatment in ED only (no forensic sampling to be undertaken)	
Infant health – last 24 to 48 hours		
Name: Contact:	**Care given in the last 24 to 48 hours**	
	Any illnesses of the infant in the last 24 to 48 hours?	
	Any medications given to the infant in the last 24 to 48 hours?	
	Body systems review	
	Feeding	
	Usual feeding	
	Feeding in the last 24 to 48 hours	
	Any changes in bowel habits in the last 24 to 48 hours	
	Sleeping	

Section completed by	Question	Response
	Usual sleeping	
	The last 24 to 48 hours (where and how placed to sleep and in what clothing)	
Time and place of death		
Name: Contact:	Address where infant was found	
	Time and location infant was found (bed, lounge, cot, bassinet?)	
	Time arrived at ED (triage time)	
Confirmation of death		
Name: Contact:	Death confirmed by whom	
	Time and date of confirmation of death	
	Location of confirmation of death	
	Has examination given an indication of cause of death?	
Family history		
Name: Contact:	Has there been a history of sudden unexpected deaths in the family, including siblings?	
	Has there been a history of recurrent syncope in the family?	
	Has there been a history of epilepsy in the family?	
	Has there been a history of drowning in the family?	
Safety of other children in the household		
Name: Contact:	Names and ages of any other children in the household	
	Any other children in the household experiencing illness?	
	Any specific child protection issues identified?	
	Any prior history of child protection concerns for this infant or other children in the family or household including Child Protection Unit presentations or mandatory reports to the Department of Communities and Justice?	

Section completed by	Question	Response
	Any concerns regarding domestic and family violence?	
	Advice received from CASACAL (if relevant)?	
	Mandatory Reporter Guide completed? Department of Communities and Justice notified?	

7.2.2. Stage 2 – Information collected in ED/Ward or other location (including online) next business day

The second medical history interview should be held with the parent/carer in-person or online in a location that is most comfortable for them. This might be at home, in a community health centre or in a quiet room at the hospital. The medical history should be collected and combined with the infant's eMR for Forensic Medicine on the next business day.

A networked paediatrician takes the Stage 2 medical history. The interview may be completed remotely.

A suitably qualified on-site staff member should be physically with the family for the medical history interview, to provide non-clinical support and assistance. This staff member does not have a clinical role.

Section completed by	Question	Response
Family History		
Name: Contact:	Adult family members	
	Name 1	
	Name 2	
	Name 3	
	Other household members	
	Name 1	
	Name 2	
	Name 3	
	Any previous health issues in adult and child family members?	
	Physical health	
	Disability	
	Mental health	
	Any diagnosed cardiac, genetic or metabolic disease in biological family	
	Medications	
	Previous medications	
	Medications in the last 24 to 48 hours	
	Alcohol/drug use (include smoking/vaping)	
	Previous alcohol/drug use	

Section completed by	Question	Response
	Alcohol/drug use in the last 24 to 48 hours	
	Any previous childhood deaths in the family	
Infant's History		
Name: Contact:	Pregnancy and delivery (neonate or preterm)	
	Perinatal history (including hypoglycaemia in perinatal period)	
	Parents/carers concerns regarding growth	
	Parents/carers concerns regarding behaviour and development	
	Infant's previous illnesses	
	Infant hospital admissions	
	Infant previous medications	
	Immunisation history (Blue Book?)	
	Developmental checks (Blue Book?)	
	Recent changes to routine	
	Last time infant saw a health professional	
Social History		
Name: Contact:	Type and nature of housing	
	Major life events	
	Wider family support networks	
	Any specific child protection issues identified in interview?	
	Any concerns regarding domestic and family violence?	
	Advice received from CASACAL (if relevant)?	
	DCJ notified?	
Events surrounding death – if information received from NSW Police/NSW Ambulance, do not ask again unless greater detail is required.		
Name: Agency: Contact:	When infant was last seen alive and by whom?	
	Who found the infant, where and when, appearance when the infant found?	
	Details of sleep environment: • Where in the room? • Type of surface, mattress, bedding, objects, overwrapping or over-heating.	

Section completed by	Question	Response
	• Face or head covered. • Co-sleeping – bed or elsewhere (specify)	
	Details of any resuscitation at home, and/or by ambulance.	
	For accidental/traumatic deaths, details of circumstances around the death, witnesses.	

7.3. SUDI Checklist – before end of shift

To be completed by SUDI Case Manager

SUDI CHECKLIST	
Completed by:	Comment
☐ Infant has been registered as a patient and eMR opened/updated	
☐ Siblings have been identified and, if appropriate, admitted for observation	
☐ If concerns that the death may have resulted from non-accidental injury, neglect or where other child protection risk factors are present, advice sought from CASACAL	
☐ If child protection concerns for siblings are present, the Mandatory Reporter Guide has been undertaken and indicated outcome actioned or scheduled for completion	
☐ Family has been told about SUDI processes and steps in coronial process	
☐ Family has been offered access to cultural and/or religious support	
☐ Mother has been provided with information on managing cessation of breastfeeding	
☐ Family has been given opportunity to discuss memory making (for after post-mortem)	
☐ Referral has been made to Forensic Medicine Social Worker including family wishes regarding memory making	
☐ Consultation with the Forensic Medicine CNC, if required. Handover to the CNC if needed.	
☐ Infant's body has been transported to Forensic Medicine	
☐ Coroner has been notified of SUDI	
☐ Stage 1 Medical History has been completed using template	
☐ Stage 2 Medical History has been completed onsite or has been arranged for next business day	
☐ NSW Health staff hot debrief has been organised before end of shift	
☐ Family has been told about family support options for when they are ready, including Red Nose's 24/7	

SUDI CHECKLIST	
Completed by:	Comment
support line 1300 308 307 and website https://rednose.org.au	
☐ Cross-agency huddle has been held	
☐ Where appropriate, referral has been made to LHD/SHN social work team	

7.4. Cross-agency Huddle – Template

This is a suggested template to use at Cross-agency Huddles.

Infant ID: _____ Date: _____

Location: _____ Time: _____

Notes taken by: _____

Present:

Name	Agency

Actions taken up to now:

Action	**Who by**

Actions to be taken in next 24 hours

Action	**Who by**

Comments

7.5. SUDI Contact List

To be completed with local contacts by and for each facility. Display this contact list in an easily located place in the emergency department

Refer to SUDI Policy

Sudden unexplained death of an infant (SUDI)

Contact List for _____ (Facility name)

DATE:

On-Call or Networked Paediatrician
Phone:

Email:

SUDI Case Manager
Phone:

Email:

On-call Social Worker
Phone:

Email:

Aboriginal Health professional with a designated cultural support role for non-clinical support
Phone:

Email:

Police Area Command/Police District
Phone:

Email:

Forensic Medicine CNC
Phone: Business hours (8am - 4:30pm):
Sydney (Lidcombe): 02 9563 9000 or Newcastle: 02 40414200

Email: NSWPATH-FASSFM-CNC@health.nsw.gov.au

Forensic Medicine Social Worker
Phone: Business hours (8am - 4:30pm):
Sydney (Lidcombe): 02 9563 9000 or Newcastle: 02 40414200

Email: NSWPATH-FASSFM-Admin@health.nsw.gov.au

Child Abuse and Sexual Assault Advice Line (CASACAL)
Phone: 1800 244 531

8. References

[1] NSW Child Death Review Team, "NSW Child Death Review Team Annual Report 2023-24," NSW Ombudsman, Sydney, Australia, 2024.

[2] K. Hunt, S. Uhm, I. Finlay, and A.-S. Darlington, "Supporting families after the unexpected death of a child," *BMJ*, vol. 389, p. e082885, Apr. 2025, doi: 10.1136/bmj-2024-082885.

[3] H. E. Jeffery, A. E. Carberry, A. Gordon, and S. Arbuckle, "The investigation of sudden unexpected deaths in infancy in Australia," *Med. J. Aust.*, vol. Online first, Feb. 2023, Accessed: Sep. 19, 2024. [Online]. Available: https://www.mja.com.au/journal/2023/218/6/investigation-sudden-unexpected-deaths-infancy-australia

[4] NSW Health, "Sudden Unexpected Deaths in Infancy (SUDI) Compliance Audit: 1 October 2019 - 30 June 2021, Draft Report," Unpublished, 2023.

[5] CDC, "About SUID and SIDS," Sudden Unexpected Infant Death and Sudden Infant Death Syndrome. Accessed: Jan. 14, 2025. [Online]. Available: https://www.cdc.gov/sudden-infant-death/about/index.html

[6] R. D. Goldstein *et al.*, "Inconsistent classification of unexplained sudden deaths in infants and children hinders surveillance, prevention and research: recommendations from The 3rd International Congress on Sudden Infant and Child Death," *Forensic Sci. Med. Pathol.*, vol. 15, no. 4, pp. 622–628, 2019, doi: 10.1007/s12024-019-00156-9.

[7] S. A. Deutsch, J. L. Macaulay, N. Smith, and A. De Jong, "Management of Sudden Unexpected Infant Deaths in the Emergency Department:," *Del. J. Public Health*, vol. 8, no. 2, pp. 14–20, May 2022, doi: 10.32481/djph.2022.05.003.