7 Minute Briefing

01 Report

"Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm"

Review Report by the Child **Safeguarding** Practice Review Panel (July 2020)

The term sudden unexpected death in infancy (SUDI) is a descriptive term, used at the point of presentation of any infant whose death was not anticipated.

02 Background

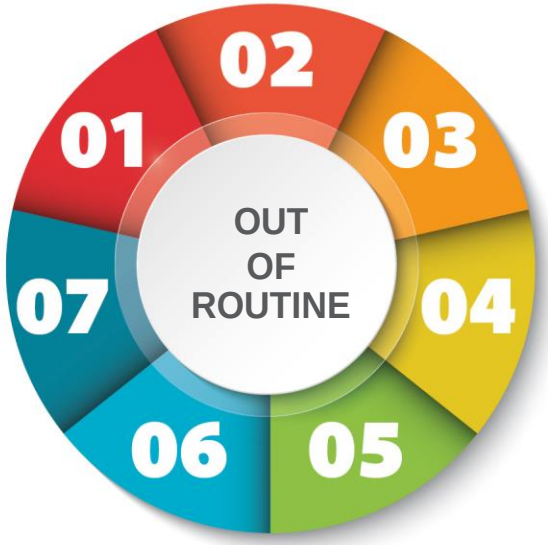
- 568 incidents were notified to the National Panel between June 2018 and August 2019,
- 40 (7%) involved infants who had died suddenly and unexpectedly, making this one of the largest groups of children notified.
- Almost all (38) of the incidents involved co-sleeping in unsafe sleep environments, often when the parent had consumed alcohol or drugs.
- 14 of these cases were reviewed in this report and they were from 12 local areas. These were representative of the 40 cases.

The review included: analysis of the above cases; fieldwork visits; discussions with key professionals and experts; a review of the research literature; an analysis of data on child death reviews and SUDI for England

03 Key Findings – 'Out of Routine'

- In 11 of the 14 cases, the last sleep of the infant was considered 'out of routine'.
- There was no suspicion in any of the cases of deliberate harm, but each death was avoidable had there been more vigilance of safer sleeping.
- Disrupted routines often led to the death with parents seeing safe sleep advice as 'optional' and flexible depending on the situation.

Predisposing risks were often combined with out-of-routine incidents or 'situational' risks, where unexpected changes in family circumstances meant an infant was placed in an unsafe sleep environment, such as: moving accommodation; a family party; arrival of a new partner; the baby being unwell; alcohol or drug use on the night in question.



04 Key Findings - Safe Sleep advice

The Report recognised the need for a tailored flexible approach to prevention for families who often already have identified background risks. Support needs to recognise and be responsive to people's lives and link to mechanisms that are understood by parents/carers to protect babies.

- The Lullaby Trust Materials were highly regarded and widely used across the 12 local areas.
- Better use of social media to 'nudge' parents to follow advice.
- Safer sleeping advice had been given to all 14 families, usually antenatally.

05 Key Findings – Parents

- Deaths could have been prevented if safe sleeping advice had been followed.
- Parents had not been able to engage with the advice.
- Understanding parents' perspectives and building relationships is key.
- Consistency is key across agencies as some parents felt that safer sleeping messages were inconsistent.

06 Key Findings – Practice

- The most successful approaches to prevention of SUDI were multi-agency and embedded in strategies for dealing with neglect, domestic abuse, mental health, substance misuse and deprivation.
- Safer sleeping advice had been given to all 14 families usually antenatally.
- A multiagency response is required not just health.
- Pregnancy described as a 'reachable moment' for practitioners.

07 Key Learning

- A better understanding of parental decision making about the sleep environment.
- Better links between work to reduce the risk of SUDI and wider safeguarding strategies.
- An investigation into whether behavioural insights and models of behaviour change can support interventions to promote safer sleeping, particularly among families with children at risk of significant harm.

Read the NSPCC briefing for further information & recommendations: Sudden unexpected deaths in infancy (SUDI): CASPAR briefing | NSPCC Learning

Or the full report

See also: The Lullaby Trust - Safer sleep for babies, Support for families