Note on terminology: 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.

1. Introduction

In 2020, The Child Safeguarding Practice Review Panel published their review of SUDI in families where the children are considered at risk of significant harm. Of the 568 serious incidents notified to the Child Safeguarding Practice Review Panel between June 2018 and August 2019, 40 involved infants who had died suddenly and unexpectedly, making this one of the largest groups of children notified. Sadly, most were preventable.

2. Methodology

The review examined 14 incidents of SUDI from 12 local areas that were representative of the 40 SUDI cases reported to the Panel between June 2018 and August 2019.
There were four parts to the review:

- fieldwork visits in 12 local areas
- discussions with key professionals and experts in respect of SUDI
- a review of the research literature
- analysis of national child death review data

3. Key findings

Almost all of these tragic incidents involve parents co-sleeping in unsafe sleep environments with infants, often when the parents had consumed alcohol or drugs. In addition, there were wider safeguarding concerns –often involving cumulative neglect, domestic violence, parental mental health concerns and substance misuse.

7 minute brief: Out of routine: A review of Sudden Unexpected Death in Infancy (SUDI) in families where the children are considered at risk of significant harm.

Safeguarding children at risk from sudden unexpected infant death - GOV.UK (www.gov.uk)

4. Key findings

In spite of rigorously delivered safer sleep messages, many of the most at risk families are either unwilling/unable to act on advice for multitude of reasons. There need to be better links between the work in local areas to reduce the risk of SUDI and wider strategies for responding to neglect, deprivation, Domestic Abuse, Parental Mental Health and Substance Misuse concerns. Professionals should adopt a supportive but flexible and responsive partnership with parents including co-production of information and support.

5. Developing a practice model

The findings suggest the need for a 'prevent and protect' practice model with 4 key components:

- robust commissioning to promote safe sleeping within a local strategy
- multi-agency action to address pre-disposing risks of SUDI for all families
- differentiated and responsive multi-agency practice
- underpinning systems, processes, tools etc.

6. National recommendations

- To explore how data from child death reviews can be cross checked with data collected through serious incident notifications to ensure learning is identified and disseminated.
- To ensure the learning from this review can be embedded in the Healthy Child Programme.
- For the Department of Health and Social Care to work with key stakeholders to develop tools and processes for frontline professionals working with families with children at risk to promote safer sleeping

7. Further research identified

- To establish the efficacy of different interventions to reduce the risk of SUDI within families whose children are at risk.
- To research the use of behavioural insights and models of behaviour change with parents.