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

Presents findings from a review by The Child Safeguarding Practice Review Panel of 14 incidents of sudden unexpected death in infancy (SUDI) from 12 local areas in England that were representative of the 40 SUDI cases reported to the Panel between June 2018 and August 2019.

July 2020

Background to the review

The Child Safeguarding Practice Review Panel (the Panel) is an independent body set up to identify, commission and oversee reviews of serious child safeguarding cases in England. It brings together experts from social care, policing and health to provide a multi-agency view on cases which raise issues that are complex, or of national importance.
This review looks at sudden unexpected death in infancy (SUDI) in families with children who are considered to be at risk of significant harm through abuse or neglect, and how professionals can support parents to ensure that safer sleep advice is embedded in parenting practice.

The review included: analysis of serious safeguarding incidents involving SUDI; fieldwork visits in 12 local areas; discussions with key professionals and experts; a review of the research literature; an analysis of data on child death reviews and SUDI for England.

Between June 2018 and August 2019, the Panel received 40 serious safeguarding incident notifications for children who had died or suffered serious harm related to incidents of SUDI. This accounted for 7% of notifications received, making it one of the largest groups of cases notified to the Panel.

Key findings

The nature and circumstances of SUDI in families with children at risk

The Panel’s in-depth analysis of 14 of the cases which involved SUDI identified a range of factors in keeping with recognised risk factors. These ‘predisposing’ vulnerabilities and risks include:

- parents co-sleeping with babies
- parental alcohol or drug use
- parental mental ill health
- evidence of neglect
- domestic abuse
- overcrowding/poor housing
- parental criminal conviction
- parents who were care leavers
- young parents.

Ten of the families were previously receiving services under child protection, child in need plans or care proceedings, whilst two were only known to universal services.

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 to different accommodation
- a family party
- the arrival of a new partner
• the baby being unwell
• alcohol or drug use on the night in question.

In 11 of the 14 reviewed cases the last sleep was considered out of normal routine. In eight cases alcohol or drug misuse was noted at the time of the last sleep.

The 14 cases reviewed demonstrated a continuum of risk. Background risks, such as limited access to preventive services and fragmentation between providers, predisposing vulnerabilities and specific situational risks all contributed to the circumstances in which the SUDI occurred.

How effective are local arrangements for promoting safer sleeping and reducing the risk of SUDI

The Panel found some examples of thoughtful, evidence informed practice, and examples of creative and flexible partnership working, including:

• preventive work at a population level
• protective work with families with additional needs and situational risks
• supporting families with children at risk to reduce the risks
• interventions to reduce the risk of SUDI in families with children at risk
• interventions to improve engagement with services in families with children at risk.

However, it also found wide variations and local inconsistencies in practice. There were concerns that approaches to preventive work did not effectively meet the needs of high-risk families and that resource and time constraints meant that practitioners were sometimes unable to engage effectively with the families that were most in need.

The review found that in all cases safer sleep advice, including information leaflets, had been given to parents and documented, frequently on more than one occasion. However, the evidence from research studies and in reviews commissioned by local partnerships suggests that parents do not always find such conversations meaningful.

Key learning and recommendations

Drawing on the findings, the Panel brought together key learning points. These have been used to inform a proposed SUDI ‘prevent and protect’ practice model for local areas, reflective questions for safeguarding partners, key national recommendations, and areas where further research is needed.

Key learning
The Panel identified key areas of learning from their analysis, including the need for:

- 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.

**Proposed practice model**

This learning was used to develop a proposed local ‘prevent and protect’ practice model by the Panel. Key features of the proposed model include:

- safeguarding partners, in conjunction with commissioners and other local providers, to incorporate action to reduce the risk of SUDI within a wider strategy to promote healthy pregnancy, good infant care and safety
- multi-agency action to address pre-disposing risks of SUDI for all families, and with targeted support for families with identified additional needs
- ensuring that safer sleep advice and risk assessment are joined up with wider considerations of safeguarding risk and plans to work with families to address safeguarding concerns
- systems and processes that support effective multi-agency practice in working with families, particularly those at high risk of abuse or neglect.

**National recommendations**

In addition to the proposed local practice model the report makes three national recommendations.

- The Child Safeguarding Practice Review Panel and the Department for Education should work with the Department for Health and Social Care, NHS England and the National Child Mortality Database to explore how data collected through child death reviews can be cross-checked against those collected through serious incident notifications.
- Public Health England should consider how the learning from this review could be embedded within the transition to parenthood and early weeks in the Healthy Child Programme.
- The Department of Health and Social Care should work with key stakeholders to develop shared tools and processes to support front-line professionals from all agencies in working with families with children at risk to promote safer sleeping as part of wider initiatives around infant safety, health and wellbeing.

**Further research**
Finally, the report identifies two areas where further research is needed to establish a stronger evidence base in relation to working with families with children at risk specifically to reduce the risk of SUDI. These are:

- practice-based research to establish the efficacy of different interventions to reduce the risk of SUDI within families whose children are at risk
- further research into the use of behavioural insights and models of behaviour change working with parents whose children are at risk to develop and deliver effective safer sleep messages and approaches.

References


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- Sign up to CASPAR [nspcc.org.uk/caspar](http://nspcc.org.uk/caspar)
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