Seven Minute Briefing:
SUDI (sudden unexpected death of an infant) PANEL REPORT

7MB - Sudden Unexpected Death in Infancy (SUDI) Panel Report

Safeguarding Children in Stockport

7-minute briefings (7MB) are intended to be simple and quick to read, teams can use them within meetings as a team-based learning exercise.

1

The Report

The Child Safeguarding Practice Review Panel published a report titled "**Out of routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm**" in July 2020. The review examined 14 incidents of SUDI from the 40 cases reported to the Panel between June 2018 and August 2019. This study was based on interviews, underpinned by factual details.

2

Risks Identified

The report **identified risks to safe sleep**. In order of prevalence these were:

- Co-sleeping
- Parental alcohol or drug use
- Parental mental ill health
- Evidence of neglect
- Domestic violence
- Overcrowding/poor housing
- Parental previous criminal conviction
- Parent care leaver
- Young parents

The above often happened with disrupted routines which led to parents not following safer sleep advice, either because they were unable to, or because they did not consider it relevant in the circumstances.

3

Promoting Safer Sleep

In all cases safer sleep advice was given, but research shows parents don't always find it meaningful. Providing parents with plausible mechanisms of harm, such as a risk of suffocation when co-sleeping on a sofa, could improve trust in the messages & planning for infant safety during disrupted routines might avoid rare but lethal scenarios

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SUDI Within Wider Strategies

Local areas must move beyond a framework that sees SUDI risk reduction in isolation from other risks and as solely the responsibility of a narrow range of health professionals.

The report encourages local safeguarding partners to adopt a practice model that encompasses reducing the risk of SUDI within wider strategies for promoting infant health, safety and wellbeing. This is structured as a prevent and protect model.

5

Prevent and Protect

Locally a prevent and protect model is suggested by the report:

- Robust commissioning to promote safer sleeping within a local strategy for improving child health outcomes
- Multi-agency action to address families risks of SUDI, targeting extra support to families with identified additional needs
- Appropriately targeted multi-agency support and challenge with families to promote safer sleeping in the context of safeguarding concerns and other situational risks
- Systems and processes that support effective multi-agency practice across the continuum of risk of SUDI

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Local Briefing Links

Safer Sleep for Babies - http://www.safeguardingchildreninstockport.org.uk/wp-content/uploads/2019/10/Safe-Sleep-for-Babies.pdf

Keeping Vulnerable Babies in Mind - http://www.safeguardingchildreninstockport.org.uk/wp-content/uploads/2019/10/Keeping-Vulnerable-Babies-in-Mind.pdf

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National Links

Full Report - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

NSPCC CASPAR briefing - https://learning.nspcc.org.uk/media/2267/out-of-routine-review-of-sudden-unexpected-death-infancy-sudi-caspar-briefing.pdf

You may also be interested in the ICON scheme – Infants Cry, You Can Cope and CONI which looks at families having a baby after experiencing a SUDI within their family.

ICON - https://iconcope.org/

CONI - https://clinical-pathways.org.uk/sites/default/files/leaflet/CONI%20%28Care%20of%20Next%20Infant%29%20Leaflet.pdf