Background:

Of the 568 serious incidents notified to the 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.

Terminology:

The focus of our review has been on families with children who are considered to be at risk of significant harm through abuse or neglect. The term 'families with children at risk' is a shorthand for this.

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

Risks 1:

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.

Conclusions:

Practitioners in all agencies working with families with children at risk need to develop a clearer evidence-informed understanding of parental decision-making in relation to the sleep environment and how this might be changed. Local Safeguarding Partners are encouraged to adopt a practice model that encompasses reducing the risk of SUDI within wider strategies for promoting infant health, safety and wellbeing

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

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

Carla Thomas

Key Findings –Prevent and Protect Practice Model 1:

- differentiated and responsive multi-agency practice with families to promote safer sleeping in the context of safeguarding concerns and other situational risks
- underpinning systems and processes with relevant policies, procedures and practice tools that support effective multi-agency practice across the continuum of risk of SUDI.

Key Findings –Prevent and Protect Practice Model 1:

- robust commissioning to promote safer sleeping within a local strategy for improving child health outcomes
- multi-agency action to address pre-disposing risks of SUDI for all families, with targeted support for families with identified additional needs

Risks 2:

it was apparent from the cases notified to the Panel that this advice, for whatever reason, is not clearly received or not acted on by some of those families most at risk. It is also clear that, for this group of families, the risks to their children extend beyond the direct risks of abuse or neglect to include wider risks to their health, development and wellbeing.