7 Minute 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.

Walsall Safeguarding Partnership

Right for Children, Families and Adults

1 Who are the Child Safeguarding Practice Review Panel?

The panel is the independent commissioner of reviews into serious child safeguarding cases with a view to improving learning, professional practice and outcomes for children. Statutory guidance in 'Working Together' sets out how the panel operates; however, the panel is independent of the Government. The panel supervises the production and quality of reviews. This is the second national review published by the panel.

2 Overview of Report

The deaths of 14 babies in 12 local authorities were examined. There have been substantial reductions in SUDI cases since the 1990s however in England/Wales at least 300 children die suddenly and unexpectedly each year. There has been a steady shift towards this happening predominantly in families from deprived socio-economic backgrounds. 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. Many of these SUDI deaths were preventable.

3 Case Study Facts

- Of the 568 incidents referred to the National Panel between June 2018 and August 2019, 40 were SUDI, all of these were babies. This makes it one of the largest notifiable groups for National Panel referrals.
- 10 of the 14 families previously received support under CP, CIN or care proceedings.
- In 8 cases, parental drug or alcohol misuse was a feature.

4 Case Study Facts continued…

- 38 of the 40 SUDI notifications involved co-sleeping with a parent, in addition there were wider safeguarding concerns such as neglect, DV, poor mental health and substance misuse.
- 63% of babies were aged less than 3 months when they died, with a peak at aged one month.
- 53% were male, 16 were White British, 9 from BAME backgrounds and 15 had no ethnicity stated.

5 Key Findings

- In 11 of the 14 cases, the last sleep of the infant was considered 'out of routine'.
- In none of the cases was there any suspicion of deliberate harm, with each death being avoidable had there been more vigilance of safer sleeping.
- Disrupted routines often led to the death, with parents seeing safe sleeping advice as 'optional' and flexible dependent on the situation.
- Identified 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 understandable mechanisms for protection.
- **The Lullaby Trust** materials were highly regarded and widely used across local authorities.

6 Key Findings continued…

- In line with good practice guidance, pre-birth assessments should commence no later than 20 weeks' gestation and completing no later than 4 weeks before the due date.
- Safer sleeping advice had been given to all 14 families, usually, antenatally.
- Understanding factors influencing parental decision making is key.
- Better links are needed between safer sleeping awareness and other key workstreams e.g., neglect, domestic abuse and substance misuse.
- Multi-agency responsibility, not just for health professionals to tackle.
- Some parents felt safer sleeping messages were inconsistent.
- Better use of social media may 'nudge' parents to follow advice.
- Pregnancy described as the 'reachable moment' for professionals

7 Recommendations

- The National Panel and DfE to work with Department for Health & Social Care (DHSC), NHS England and National Child Mortality Database to explore how data collected via child death reviews can be cross checked with referrals to the Panel.
- Public Health England to consider how the learning from this review is embedded in transition to parenthood and early weeks work.
- DHSC to develop shared tools and processes to support frontline staff promoting safer sleeping.
- Need for practice-based research of different interventions to prevent SUDI, as well as development of a 'prevent and protect' model.
- Read the full report "Out of Routine"