Support frontline workers to engage parents struggling with safer sleeping advice

The government needs to develop new tools to help prevent the sudden unexpected death of infants (SUDI), says a new review by the Child Safeguarding Practice Review Panel.

The independent panel of experts reviews serious child safeguarding incidents, when children have died or suffered serious harm, to learn how to improve the safeguarding system.

While the overall numbers of babies dying from SUDI are decreasing, a worrying number of deaths have been notified to the panel as serious child safeguarding incidents. Between June 2018 and August 2019, the deaths of 40 babies from SUDI were reported to the panel. Most of whom died after co-sleeping in bed or on a chair or sofa, often with parents who had consumed drugs or alcohol.

The review reveals families with babies at risk of dying in this way are often struggling with several issues, such as domestic violence, poor mental health or unsuitable housing. It found that these deaths often occur when families experience disruption to their normal routines and so are unable to engage effectively with safer sleeping advice.

Due to coronavirus (COVID-19) and the associated anxieties about money, social isolation and mental health issues, disruptions that led to the deaths of these infants may be more prominent at present.

To address this, the panel is calling for local areas to reduce the risk of SUDI by incorporating it into wider strategies for responding to social and economic deprivation, domestic violence and parental mental health concerns. This should be backed up by new government tools and processes to support frontline practitioners and local safeguarding partners to make these changes.

Interim Chair of the Child Safeguarding Practice Review Panel, Karen Manners QPM said:

> The unexpected death of an infant is a tragedy and although it's not always predictable, some babies appear to be more at risk.
>
> Families with children at higher risk of SUDI are often struggling with several issues, such as domestic violence, poor mental health or unsuitable housing, and infants may die after co-sleeping on a sofa or with parents who have consumed drugs or alcohol.
>
> Therefore, it's vital that practitioners work together to help

> parents understand how to make sure that every sleep is a safe one for their baby.

Leading SUDI expert and Child Safeguarding Practice Review Panel Member, Prof Peter Sidebotham said:

> It’s important that we give all families information about safe sleeping, but for some families who are struggling with multiple issues, the existing information is simply not enough.
>
> This is not about blaming parents who have suffered such tragedies. This is a societal issue and we need to listen to and talk with families realistically and honestly so we can make sure that their babies sleep safely all the time.

Chief Executive of The Lullaby Trust, Jenny Ward said:

> This review highlights that safer sleep, despite being the best way to reduce the risk of SUDI, is not always easy to follow. We need to identify the families who require additional support to help make decisions that are right for them and their baby, particularly when faced with an unexpected situation such as when your baby is unwell or you are staying away from home.
>
> Despite great reductions in SUDI rates over the past few decades there is still a lot of work to be done, and we know the devastation the death of a baby has on families. We welcome the recommendations and look forward to sharing our learning and knowledge around communicating with families to prevent more babies from dying.

The review examines the deaths of 14 babies from 12 local areas to understand how professionals can best support parents to ensure that safer sleep advice is heard and embedded.

The findings show that:

- families living within a context of recognised background risks, such as deprivation and overcrowding, domestic violence or poor mental health, are at heightened risk of losing a baby to SUDI – all those working with families need to recognise that and work together – this is not just an issue for midwives and health visitors
- we need a flexible and tailored approach to prevention that is responsive to the reality of people’s lives – that means talking honestly with parents about how they will cope in different situations to ensure every sleep is safe
- the best local arrangements for promoting safer sleeping involve a range of professionals as part of a relationship-based programme of support,

embedded in wider initiatives to promote infant safety, health and wellbeing
- a prevent and protect practice model should be locally adopted to recognise the continuum of risk of SUDI, with support and interventions that are graded to reflect the needs of different families

The review makes recommendations for the Department for Education, Department of Health and Social Care, Home Office and Public Health England 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 well-being
- work with 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
- embed learning from this review as part of the refresh of the high impact areas in the Healthy Child Programme and the specification for health visiting

The review also recommends that further practice-based research is undertaken to establish the efficacy of different interventions to reduce the risk of SUDI and into the use of behavioural insights and models of behaviour change. The panel is exploring options to commission this research and is interested in hearing from organisations to partner on this work.

The panel's annual report shows that babies are most at risk of serious harm and death from abuse and neglect. Therefore, it is undertaking a further in-depth review into the non-accidental injury of infants under one year old.

The Child Safeguarding Practice Review Panel is an independent body that was set up to identify, commission and oversee reviews of serious child safeguarding cases. It brings together experts from social care, policing and health to provide a multi-agency view on cases which they believe raise issues that are complex, or of national importance.

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 4 parts to the review:

- fieldwork visits in the 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 2018 to 2019

This was a qualitative study, based on interviews with practitioners and families, underpinned by factual details from each case.

Between 29 June 2018 and 30 June 2020, the panel received 757 rapid reviews relating to child abuse and neglect. Of these:

- 198 (26%) involved the death or serious harm of babies and young children due to non-accidental injury
- 62 (8%) involved the death of a child under one year old due to SUDI

Panel member, Dr Peter Sidebotham is available for interview on behalf of the panel. Please contact Amina Makele on 07889133791.