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

NHS Dorset Clinical Commissioning Group

The Child Safeguarding Practice Review Panel (CSPR) is independent and commissions reviews of serious child safeguarding cases. The aim is to focus on improving learning, professional practice and outcomes for children, nationally and locally.

In July 2020 the Panel published 'Sudden Unexpected Death in Infants (SUDI) Report having received 40 notifications (between 6/2018 - 08/2019) for children who had died or suffered serious harm related to incidents of SUDI.

This was 7% of all cases notified to the Panel. The review examined 14 cases, from 12 local areas that were representative of the 40 SUDI cases reported.

The review set out to answer the question:

In families with children considered to be at high risk of significant harm through child abuse or neglect, how can professionals best support the parents to ensure that safer sleep advice can be heard and embedded in parenting practice so as to reduce the risks of SUDI?

Findings

- Cases reviewed demonstrated a continuum of risk where predisposing risks were often combined with out-of-routine incidents or 'situational risks'
- Co-sleeping was a feature in 38 of the 40 cases.
- In 11 of the 14 reviewed cases the last sleep was considered out of normal routine.
- Parental alcohol and drug use were common, as were issues related to parental mental ill-health, evidence of neglect and domestic violence.

Responding to SUDI – CONTINUUM OF RISK

Pre-disposing risks of SUDI

- Smoking in pregnancy
- Maternal obesity
- Premature birth
- Low birth weight
- Socio-economic deprivation
- Low-income household
- Overcrowding and temporary accommodation
- Adverse childhood experiences
- Previous safeguarding concerns
- Mother under 20

Situational risks

- 'Late booking'
- Cumulative neglect
- Domestic abuse, mental health concerns, substance misuse and other safeguarding risks
- Reluctant engagement with professionals
- Co-sleeping

Other pre-disposing risks

- Out-of-routine / critical incidents / unsafe sleep environment

Prevent & Protect

'Prevent and Protect' practice model proposed recognising a continuum of risk of SUDI, with support and interventions that reflect the needs of all families, including those with additional needs and those with children at risk.

Characteristics of effective interventions were identified as:

personalised, culturally sensitive, enabling, empowering, relationship building, interactive, accepting of parental perspective, non-judgemental and are delivered over time.

Four key conclusions

- Parents need advice from someone they trust and believe
- Co-sleeping is too common and too complex to apply a simple ban
- Provide parents with plausible mechanisms of harm, e.g. risk of suffocation when co-sleeping on a sofa
- Planning for infant safety during disrupted routines might avoid rare but lethal scenarios

Recommendations

- Explore how data from serious incident reporting can be cross checked with that from child death reviews.
- Consider how Public Health England could embed the learning within the transition to parenthood and early weeks (Healthy Child Programme).
- Develop shared tools and processes for all front line staff working with families with children at risk to promote safer sleeping as well as infant safety, health and wellbeing.

Research

- Practice-based research to establish the efficacy of different interventions to reduce risk of SUDI within families whose children are at risk
- Research into use of behavioural insights and models of behaviour change to develop and deliver effective safer sleep messages and approaches, in families where children are at risk.

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

Out of routine:
Sudden unexplained death in infancy

NHS
Dorset
Clinical Commissioning Group

What am I going to do when things are different?

How can we as professionals get the message to grandparents and other carers?

1

1980s over 2000 cases of Sudden Unexpected Death in Infants (SUDI) per year in England. This reduced to <400 in the late 1990s.

Now there are approximately 200 cases of SUDI per year.

BUT, we are seeing more SUDIs occurring in families where there are recognised vulnerabilities and risks.

2

In July 2020, Child Safeguarding Practice Review Panel published their report into SUDI*

The report highlights **the importance of planning for 'out of routine' events where a child's normal sleeping arrangements may be changed**, especially when this involves alcohol.

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

3

Findings

- A continuum of risk where predisposing risks were often combined with out-of-routine incidents or 'situational risks'
- Co-sleeping was a feature in 38 of 40 cases.
- In 11 of 14 reviewed the last sleep was considered out of normal routine.
- Parental alcohol and drug use were common, as were issues related to parental mental ill-health, evidence of neglect and domestic violence.

4

Responding to SUDI – CONTINUUM OF RISK

Pre-disposing risks of SUDI
- Smoking in pregnancy
- Maternal obesity
- Premature birth
- Low birth weight
- Socio-economic deprivation
- Low-income household
- Overcrowding and temporary accommodation
- Adverse childhood experiences
- Previous safeguarding concerns
- Mother under 20

Situational risks
- 'Late booking'
- Cumulative neglect
- Domestic abuse, mental health concerns, substance misuse and other safeguarding risks
- Reluctant engagement with professionals
- Co-sleeping

Other pre-disposing risks
- Out-of-routine / critical incidents / unsafe sleep environment

5

Why is this important?

All families receive 'safe sleeping' guidance from health professionals, some families are unable or unwilling to follow some of the advice.

It is often in 'out of routine' circumstances that SUDI will occur.

We all have a role to play in advising and supporting families and as a result:

Lives could be saved

6

Further information re Safe Sleeping

The Lullaby Trust
www.lullabytrust.org.uk/safer-sleep-advice

NHS website
www.nhs.uk/conditions/sudden-infant-death-syndrome-sids

7

What can we do?

- Listen to parents, grandparents and carers
- Build trusting relationships
- Understand constraints to safer sleeping messages
- Be flexible in our approaches to ensure our message makes sense to those we are providing it to

Provide support and interventions that reflect the needs of all families, those with additional needs and those with children at risk;

Explain what the risks are and why?
e.g. if sleeping with your baby when you are under influence drugs or alcohol you could smother your baby.

Ask families to consider **"what am I going to do when things are different?"**