















Embedding safeguarding in practice by supporting a learning culture

Re-envisaging Professional Curiosity & Challenge

A multi-agency approach to preventing Sudden Unexpected Death in Infancy (SUDI)

Thank you for joining us – we will start at 09:15.

We kindly ask that you keep yourself on mute whilst our speakers are presenting. Thank you.

















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Nicola Eschbaecher

Designated Nurse for Child Death Reviews, Surrey Heartlands ICB Member of - Surrey Child Death Overview Panel (CDOP)

- SSCP Case Review Group (CRG)

















Thank you to everyone involved in making this ambitious project a reality

With particular thanks to

- Our speakers Emeritus Professor Jonathan Dickens, Dr Anna Pease and Natalie Price
- Nicola Mundy, Liz Cassini, Tom Stevenson, Alison Cutler, Julia Bird and Barbara Sowa
- Case Review Group and the Roundtable test group
- SSCP Executive for endorsing and hosting the project
- Our future lunch and learn speakers who have pledged their support already, and those who are yet to join the project
- The team already working behind the scenes to set up the September event
- Everyone for joining us today for this half-day event

















Since 2022 we have been working toward joining the work from across the networks

In response to an impact mapping exercise, impact report and listening to the feedback from across the practitioners

- Surrey CDOP (Child Death Review)
- Surrey SSCP
 - Case Review Group (Rapid Reviews/LCSPRs)
 - Learning from Practice Group
- Surrey Healthy Schools
- Area Schools Team

From September...

Surrey Safeguarding Adults Board and Domestic Abuse Related Death Reviews (formally DHR)

















Aims of the work:

- To raise awareness, to save lives and to prevent deaths wherever possible
- To share a set of questions that can support professionals to be 'curious' within their work, and to offer challenge to our mindsets and ways of thinking
- To take professional curiosity as a 'lens' through which we consider key learning areas
 - SUDI, Suicide, Neglect etc...
- To help put some substance behind the abstract term, and to think differently about how
 we can learn about professional curiosity in real terms, through real topics
- To create a single repository for everyone to access that not only captures the learning, but also shares the fantastic work that is happening across the County
- To embed the learning within wider practice for ALL agencies across Surrey















What is SUDI?

SUDI stands for Sudden Unexpected Death in Infancy <12 months of age

- No definitive cause can be identified following postmortem and investigation
- Process of exclusion which is different to most other causes of death

If after all investigations, there is absolutely no explanation and no other causes identified, it may be classified as SIDS, which is a subcategory of SUDI – less commonly used as bed sharing can confuse the certainty, which may also result in the use of 'unascertained' SIDS – Sudden Infant Death Syndrome

Term 'Cot Death' no longer used

Understanding SIDS and SUDI – BASIS (basisonline.org.uk)

Key considerations

- Risk factors for SUDI risk factors are not definitive causes
- Overlay is very unlikely to be intentional
- If it is considered neglectful care, it can be difficult to prove
- Carers are often confused about how they woke up, so proving cause and intention beyond reasonable doubt can be problematic

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Why SUDI prevention is so important

SUDI already appears heavily in the work of many and is well embedded...

- Surrey Child Death Review Team and Surrey Child Death Overview Panel (CDOP)
- National Child Mortality Database
- Surrey Safeguarding Children Partnership
- Case Review Group, Learning from Practice Group Rapid Review, Local Child Safeguarding Practice Reviews
- National Child Safeguarding Practice Review Panel
- Surrey 0-19 Teams Health Visiting
- Surrey Maternity Teams
- Surrey Neonatal Outreach
- Surrey Police Child Death Investigation
- Surrey Childrens Services working with families
- Surrey GP Services















Why SUDI prevention is so important

But SUDI is also relevant for others who may see or hear signs of increased risk...

- Anyone who works with families who have a baby in any capacity
- Anyone who visits a home where a baby may be sleeping
- Anyone who supports wider family members who may care for baby directly –siblings, grandparents, aunts, uncles, foster carers
- Anyone teaching the future generation of parents
- Anyone who offers lessons in babysitting
- Anyone who has a service where a baby may be in attendance indoors schools, GP surgeries, hospitals, government services (housing, benefits etc), birth registration or attending TAF, CIN, CP meetings
 - Long periods sleeping in a car seat also increases the risks (no more than 2 hours in a 24-hour period)
 - For a baby who is not at any increased risk premature, respiratory or muscular condition, poor tone/head control
 - Long periods in an outdoor coat (in a car seat) can increase risks of overheating
 - Car seats and SIDS The Lullaby Trust

















Not just another training session...



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Overview of the learning journey

- Launch date today
- Series of lunch and learns throughout the year
 - Topics include learning from reviews and preventing SUDI in a variety of settings such as acute care, social care, prison care, educational settings, community services, specialist provision, third sector and many more
- Roundtable discussion events throughout the year with different topics
 - Opportunities and challenges, role of fathers and wider family, culture
 - Anyone can join, book online, dates will keep being added until June next year
- Feedback collected at points throughout the year
- Lunch and Learns / Roundtable discussions will keep rolling to next year when we will have a further online learning event with updates and new learning
- From September a similar model will launch the theme of all-age suicide prevention

















Critical Thinking Underpins Professional Curiosity

- Misconception that critical thinking is about being negative or finding fault
- Critical thinking is all an educational theory and form of thinking
 - It prompts you to question, analyse, interpret and evaluate a variety of sources and viewpoints to create a structured analytical judgement, that also considers the reliability and validity of what you are presented – not one viewpoint
- To do this effectively, you must be aware of your own biases, emotional reasoning and assumptions – this can be challenging, but regular reflective practices and supervision can really help

















5 steps to

What do I know conclusively, what do I think but can't prove, what don't I know yet, what do I think I need to find out?

embedding

Is there anything about what I think, see, hear, feel or experience that makes me feel uneasy? Why is this?

professional

Have I tested and questioned my assessments, biases and assumptions? Have I approached this with an open mind?

curiosity

If I think, see, hear, feel or experience something different to others, why may this be happening?

in Surrey

On reflection, what could I have done differently and why? What do I need to do next?

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Agenda

Programme:

9.15am	Welcome, introductions and purpose – Nicola Eschbaecher, Designated
	Nurse for Child Death Reviews, Child Death Review Team and Surrey
	CDOP
9:30am	Re-envisaging professional curiosity - Jonathan Dickens, Emeritus Professor
	of Social Work, University of East Anglia
10.30am	BREAK
10:45am	Inequalities in SUDI deaths and interpretation of risk advice in higher risk
	families - Dr Anna Pease, Research Fellow, Centre for Academic Child
	Health, University of Bristol
11.45am	Safeguarding and safer sleep - Natalie Price, Specialist Nurse for Child
	Death Reviews, Surrey Heartlands ICB
12.15pm	Plenary and way forward – Nicola Mundy, Child Wellbeing Professional and
	Lead for Learning from Child Deaths.
12.25pm	CLOSE - Alison Cutler, Partnership Development Manager, Surrey
	Safeguarding Children Partnership

















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Thank you for listening.

For more information about the learning project please visit the SSCP website

Re-envisaging Professional Curiosity & Challenge - Surrey Safeguarding Children Partnership (surreyscp.org.uk)

5-Steps-to-Embedding-Professional-Curiosity-1.pdf (surreyscp.org.uk)