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)**

Roundtable Event 1: Opportunities and challenges for SUDI prevention

Nicola Eschbaecher
Designated Nurse for Child Death Reviews, Surrey Heartlands ICB

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
- **Risk factors are not causes**
- Overlay difficult to prove and very unlikely to be intentional
- Often confused about how they woke up, so proving beyond reasonable doubt can be problematic

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

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

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

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Why SUDI prevention is so important

But SUDI is also relevant for others who may see/spot 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 – foster carers, siblings, grandparents, aunts, uncles
- Anyone teaching the future generation of parents
- Anyone who offers lessons in babysitting

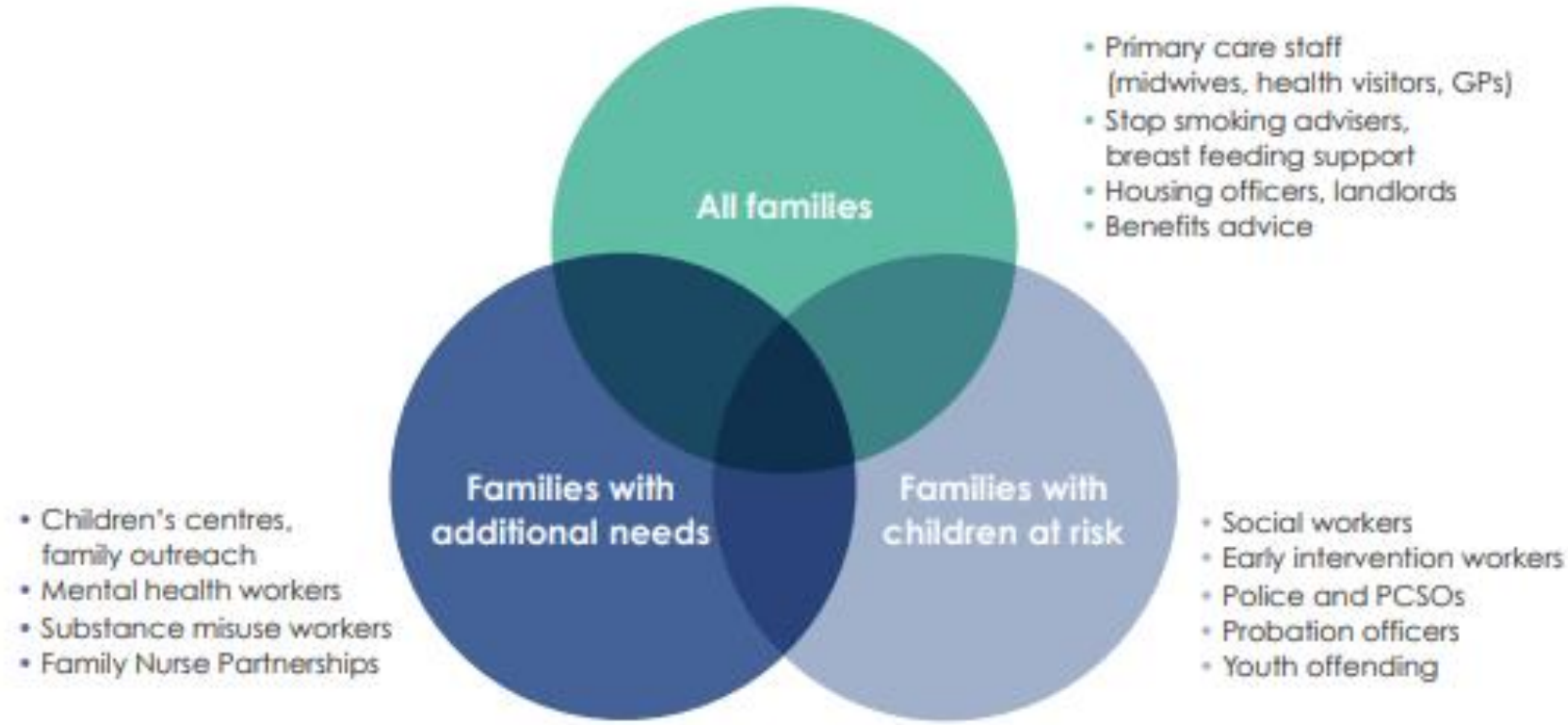
- Anyone who has a service where a baby may be in attendance indoors - schools, GP surgeries, hospitals, government services (housing, benefits etc), birth registration or attending TAF, CIN, CP meetings
  - Long periods sleeping in a car seat increases the risks (no more than 2 hours in a 24-hour period)
    - 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]

Why SUDI prevention is so important

Figure 5: The SUDI continuum of risk: key professionals

CSPRP - Out of Routine (2020)



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Pre-disposing risks of SUDI

2

- 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

- Engaging with HV, midwifery and GP support
- Promoting breastfeeding and smoking cessation
- High quality and engaging safer sleep information including safer sleep advice staged and differentiated in line with ante-natal and post-birth cycle

- Targeted safer sleeping advice and support from midwives, HV and GPs
- Effective, timely, consistent and grown-up safer sleep conversations
- Early help and targeted support for vulnerable parents – 'coaching' model
- Adult-focused, child safeguarding aware, advice and support signposting from other professionals

Situational risks

3

- '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

- Up-to-date view of the household circumstances and current risks
- Mental health support – awareness of impact on parenting capacity
- Domestic abuse – including risks in separated families
- Understand patterns of alcohol and substance misuse – and signpost support

Multi-agency systems and processes

4

- CIN and CP plans with impact
- Multi-agency guidance on safer sleep with differentiated training offer
- SUDI risk included in thresholds
- Effective risk assessment processes and timely review of safeguarding risk
- Safer sleep assessment and risk tool
- Safer sleeping risk in relevant policies, procedures and practice tools
- Service culture promotes 'authoritative practice'

CSPRP - Out of Routine (2020)

[Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (publishing.service.gov.uk)]

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CSPRP - Out of Routine (2020)

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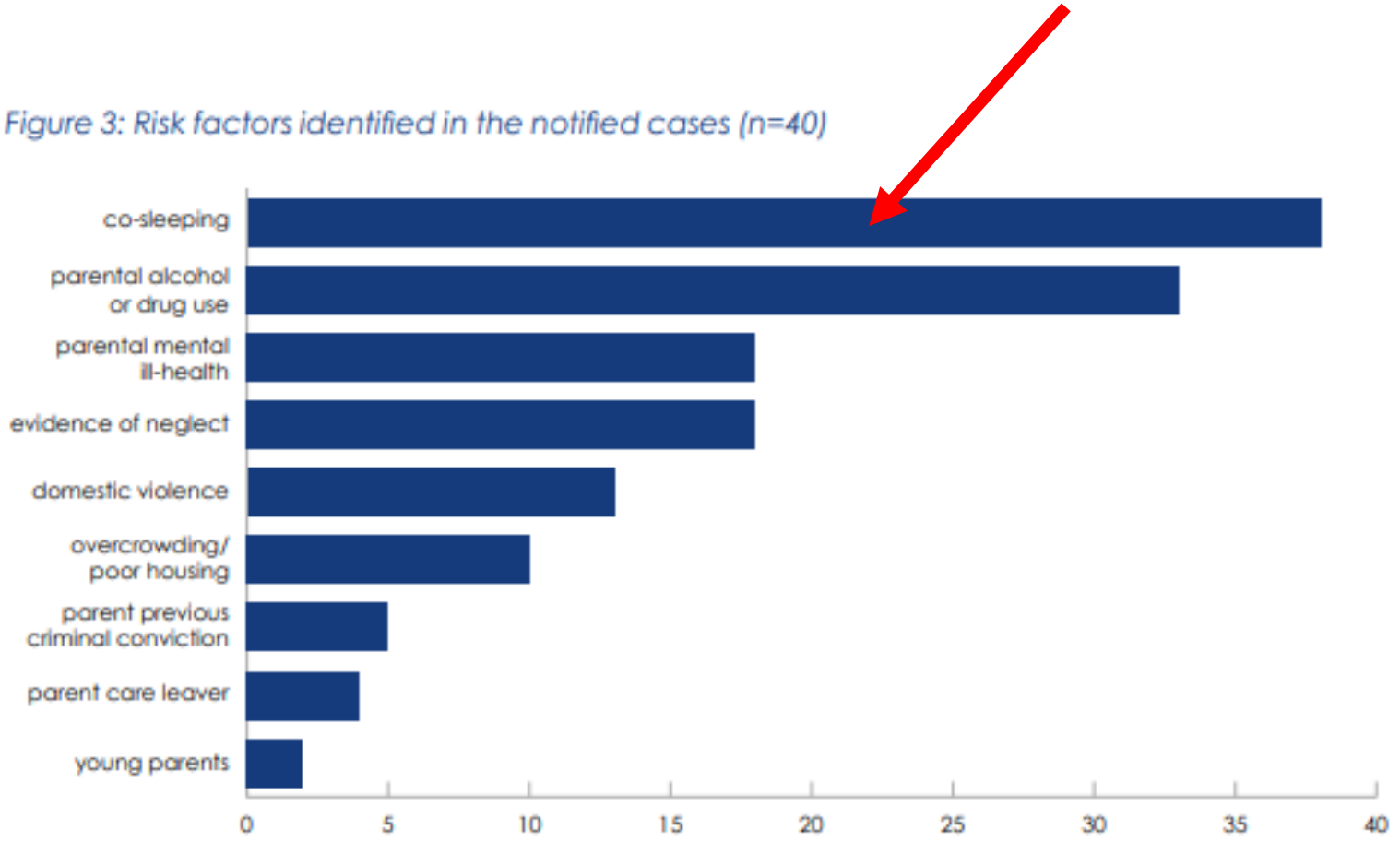
Figure 3: Risk factors identified in the notified cases (n=40)



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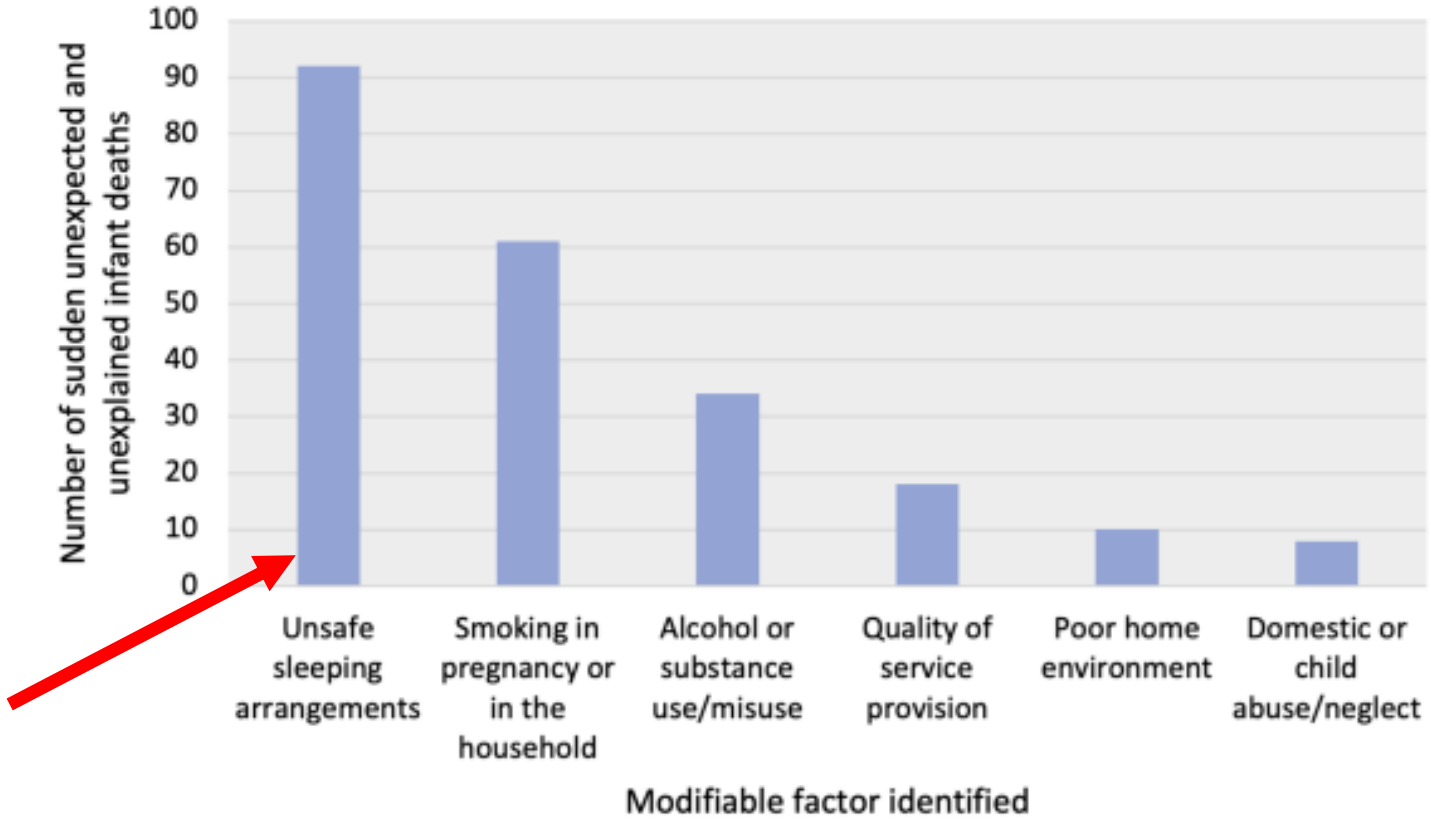
NCMD SUDI Report (2022)

Figure 7: Sudden unexpected and unexplained infant deaths in 2020, by modifiable factor recorded



[Sudden, unexpected deaths | NCMD]

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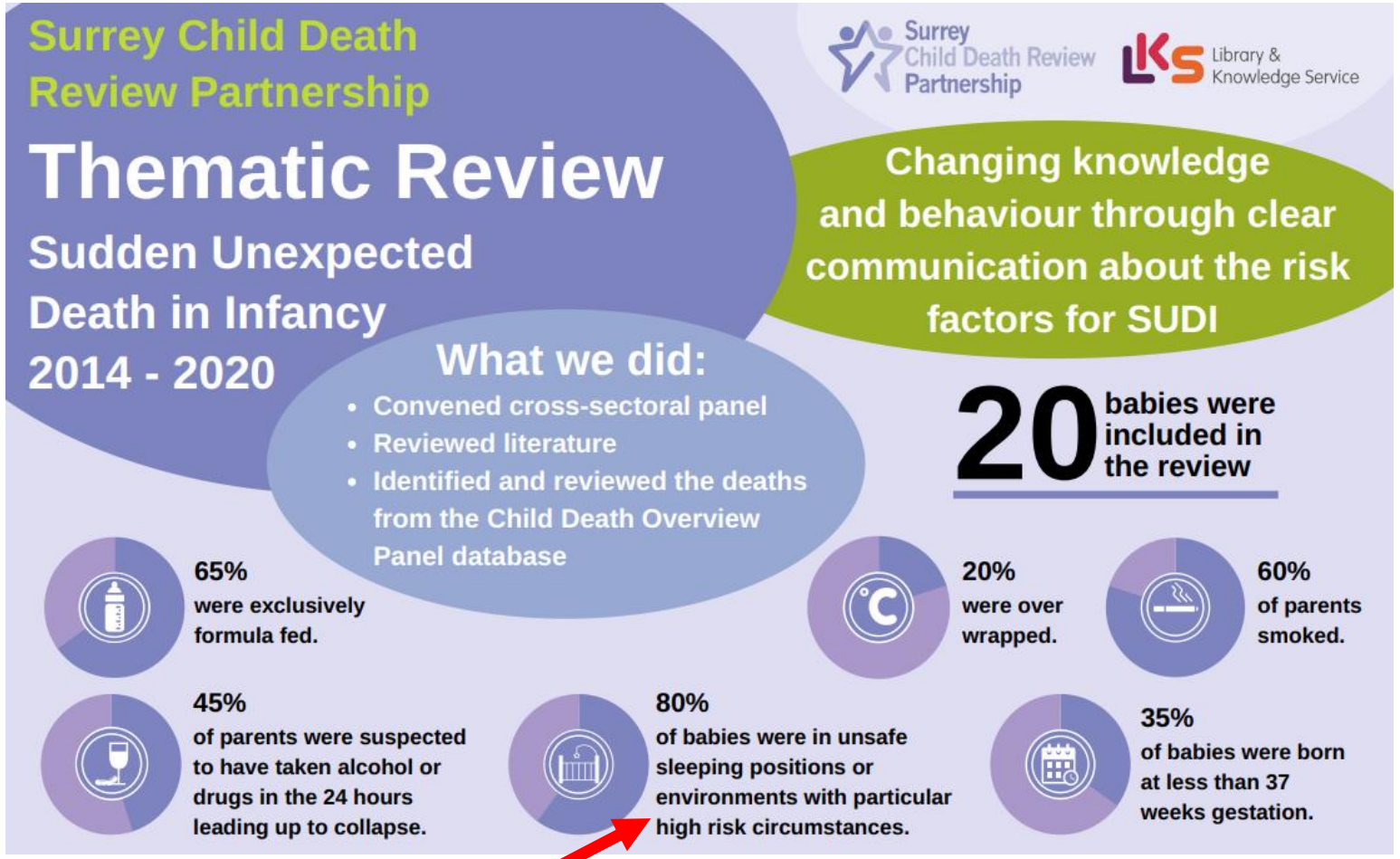
Surrey CDOP SUDI Report (2022)



[Child-Death-Review-Partnership-SUDI-thematic-review-002-1.pdf (surreyscp.org.uk)]

[Infographic A3 (surreyscp.org.uk)]

[Safer Sleep Re-audit (surreyscp.org.uk)]

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Surrey CDOP Safer Sleep Audit Report (2023)

Methodology:

9. The Child Death Review team attended Child Health Clinics within the catchment area of each of the 5 Acute Hospitals across Surrey over a six month period April – October 2022. At each clinic setting, the parent/s were approached and asked to contribute to the audit by allowing a review of the Safe Sleep Assessment contained within their PCHR/Red book and a discussion on their understanding of safe sleep advice. The audit tool and the reason for auditing were explained to each parent and their consent to participate was sought.

[Safer Sleep Re-audit (surreyscp.org.uk)]

Recommendations:

20. Full implementation of the SUDI thematic review recommendations on completion of the red book before day 5 is essential if we are to ensure that these conversations are taking place with parents and are documented.

21. There should be signposting to evidence-based advice and clear conversations on the modifiable factors which increase the risk of SUDI.

SSCP LCSPR – Rowan (2023)

Recommendation 1: (a) The SSCP to disseminate the 7 Minute Briefing: Learning from Pre-Birth Assessments, January 2022, with a requirement that it is recommended reading for all practitioners working with parents and children. (b) If a vulnerable baby is living in the care of grandparents (with or without the presence of their parent), an assessment of their parenting capabilities and skills should be a pre-requisite before any such placement is made; especially if the child is subject to a Child Protection Plan, which is reliant on the care offered by the grandparents.
Recommendation 2: Partner agencies are to be reminded that when parents are children themselves, their needs and wellbeing should be recognised, and considered a priority, together with that of the need to safeguard their child.
Recommendation 3 Consideration should be given to exploring the possibility of young, teenage mothers being offered the services of the Perinatal Mental Health Team when it is evident that their health and wellbeing is at risk, and sufficient support for their mental health cannot be provided by the services of the FNP (Family Nurse Partnership).
Recommendation 4 As required by existing SSCP policy, GP Practices should be informed when a child is subject to a Child in Need Plan, to ensure that information relevant to safeguarding is shared.
Recommendation 5 **(a)** The SSCP to seek reassurance that the framework concerning safe sleeping is embedded for use by practitioners working with families where young infants are at risk because of unsafe sleeping arrangements. **(b)** Such a framework should include a requirement that professionals visiting the home should ask to see where a baby is sleeping to seek assurance that the arrangement is safe.

Becky-SCR-Final-Report-February-2021-1.pdf (surreyscp.org.uk)

Child-ROWAN-Report-11-August-2023-FINAL.pdf (surreyscp.org.uk)

SSCP-7-Minute-Briefing-SCR-BECKY.pdf (surreyscp.org.uk)

SSCP-7-Minute-Briefing-HAZEL.pdf (surreyscp.org.uk)

SSCP-7-Minute-Briefing-Safer-Sleeping-re-Child-Cypress-July-2023.pdf (surreyscp.org.uk)

SSCP-Safer-Sleep-7-Minute-Briefing-Dec-2022-1.pdf (surreyscp.org.uk)

SSCP-7-Minute-Briefing-Professional-Curiosity-November-2023-final.pdf (surreyscp.org.uk)

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SSCP SCR Becky (2021)

4.1 Surrey Safeguarding Children Partnership ['SSCP'] disseminate the learning from the National Panel's review and Surrey CDOP's own thematic review[25] into SUDI and revise their policy and practice guidance to ensure that where there are additional risk factors, such as parental alcohol misuse, mental ill health, domestic abuse or unstable housing conditions this risk is addressed directly within child protection plans and/ or PLO assessments.

[SSCP-7-Minute-Briefing-SCR-BECKY.pdf (surreyscp.org.uk)]

4.2 Midwifery teams, health visiting services, specialist secondary support agencies and SCS where children are CiN or on CP plans should provide the SSCP with assurance that safe sleeping assessments and safety plans have been conducted. All partner agencies should give consideration to identifying the increased risk of SUDI where there is parental alcohol or substance misuse. CSC should ensure that preventative measures expected to be taken by parents and care givers are given distinct actions within any child protection plan, allowing practitioners working with the family to refer to this and reinforce the safe sleeping message. Practitioners working directly with the family and care givers need to continually test their understanding of the message and what measures they have put in place to keep the baby

[Becky-SCR-Final-Report-February-2021-1.pdf (surreyscp.org.uk)]

4.4 All relevant agencies are to provide the SSCP with assurance that they have disseminated the learning from the National Panel's review into SUDI. The SSCP also seek assurance that partner agencies have aligned organisational policy and practice guidance with any revisions to the SSCP Safeguarding Procedures identified following implementation of recommendation 1 above so that practitioners from across health and social care disciplines understand the increased risks of SUDI to children where there are concerns regarding neglect and their role in reinforcing safer sleeping advice and monitoring adherence to this.

4.9 In line with the national panel's review report the SSCP should consider developing a SUDI prevent and protect practice model that recognises the continuum of risk of SUDI, with support and interventions that are graded to reflect the needs of different families. This should provide practical guidance to all practitioners working with families where domestic abuse, mental ill health and substance misuse is a factor on the powers available within the existing legal framework to pro-actively gather evidence of compliance with child protection plans.

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What increases the risks of SUDI?

- Co-sleeping that is unplanned – baby or parental illness, holiday, tired, relatives staying…
- Drugs, Alcohol, Prescription medication that alters arousal (anti-depressants)
- Baby in the middle between adults
- Risk of pillows, duvets and other bedding
- Other children in the bed
- Smoking (during and after pregnancy)
- Room temperature <16 or >than 20°C
- Young parents <20 years
- Adverse childhood experiences of parents
- Maternal obesity
- Previous safeguarding concerns
- Increased risks of SIDS
    - Premature (before 37 weeks), low birth weight (<2.5kg)

Smoking

- Opportunities to talk about smoking cessation
- Pre-birth
- In hospital
- After delivery
- Up to 5 years
- Over 5 years
- Hospital attendances, GP attendances, Statutory visits
- Included in support plans for families
- Information and education opportunities

[One You Surrey | Free Health & Wellbeing Service]

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Situational Risks

- Late booking
- Cumulative neglect
- Domestic Abuse
- Mental Health concerns
- Safeguarding concerns
- Reluctant engagement with professionals
- Temporary accommodation and overcrowding
- Socio-economic deprivation

CSPRP - Out of Routine (2020)

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What can professionals do?

CSPRP - Out of Routine (2020)

Up-to-date view of the household circumstances and current risks

Mental health support – awareness of impact on parenting capacity

Domestic abuse – including risks in separated families

Understand patterns of alcohol and substance misuse – and signpost support

[Co-sleeping with your baby: advice from The Lullaby Trust - The Lullaby Trust]

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KEY SAFER SLEEP ADVICE

Lie your baby on their back

Keep the sleep space clear

Use a firm, flat, waterproof mattress

Keep your baby smoke-free

Avoid your baby overheating

Sleep your baby in the same room as you for at least the first six months

[How to reduce the risk of SIDS for your baby - The Lullaby Trust]

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Roundtable Discussion

- How does or could safer sleep feature within your role?
- What are the strengths and opportunities within your role?
- What barriers have you experienced, or can you foresee?
- How could we work together as professionals to support families to make safer sleep choices?
- What do you feel you or your teams need to move this forward?

Slide Links

Car seats and SIDS - The Lullaby Trust

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

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Sudden, unexpected deaths | NCMD

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