Sudden Unexpected Death in Infants (SUDI)

14th July 2021, 9:00 – 12:00

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Please use the Chat function to contribute to the Forum – you can also use it to post any questions – we'll monitor and pick them up as we go along

You can also use the 'raise your hand' function if you wish to ask a question and we'll pick those up too at convenient points

Video – please enable your video when asking a question or making a comment – NB it may improve connectivity if you disable video at other times

Audio – please mute your microphone when you are not speaking to minimise background noise

A copy of the slides will be provided after the event for you to refer to

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Aims & Objectives

Reduce Risk of SUDIS occurring - particularly deaths where unsafe sleeping a factor

1. Explain what Sudden Infant Death Syndrome (SIDS) is
2. Highlight the factors which make some babies more vulnerable to SIDS
3. Explain what safer sleep is and help you identify risk factors
4. Discuss tips on talking to parents/ carers about safer sleep and the barriers to the advice being followed
5. Raise awareness of the learning from the National SUDI Review “Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm” and the local response to it

Terminology
Child Death Review. Statutory Guidance 2017

- SUDI - death (or collapse leading to death) of an infant up to 2 years, which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent.
- SUDI (explained) – where cause has been found
- SUDI (unexplained) SUDI (under 12 months) where no clear cause of death, but don't fit SIDS e.g. , deaths in which the history, scene or circumstances suggest a high likelihood of asphyxia but in which positive evidence of accidental asphyxia is lacking).
- SIDS - death occurs during normal sleep, which remains unexplained after a thorough investigation including a complete post- mortem examination and review of the circumstances of death and the clinical history.

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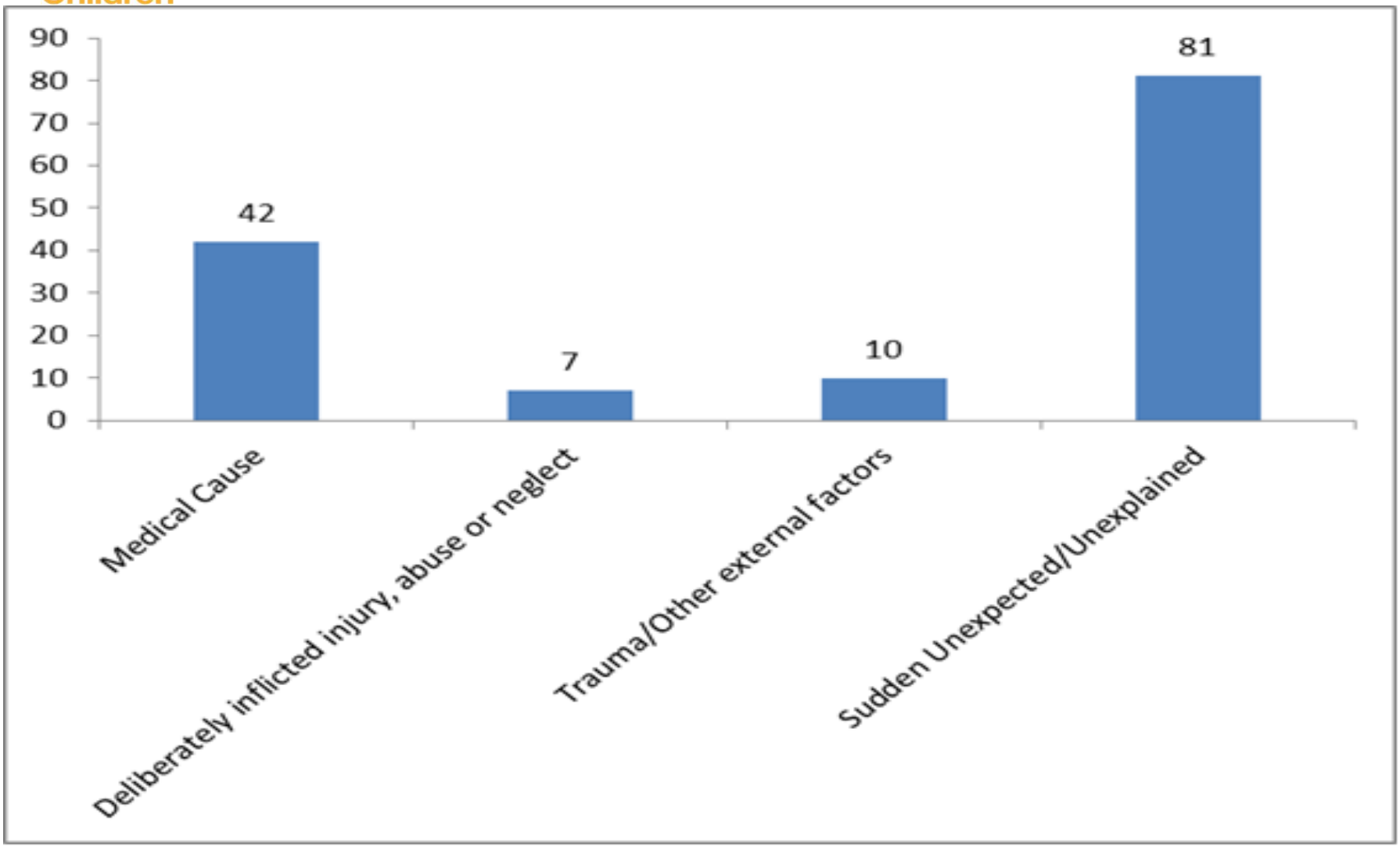
Child Death Review

- Historically police carried out investigations on behalf of Coroner as a single agency
- Miscarriages of Justice
- Joint Agency Response 2008
- Home Visit
- Child Death Overview Panel (CDOP)
- National Child Mortality Database
- Ensure Families are supported
- Themes, share learning, reduce mortality

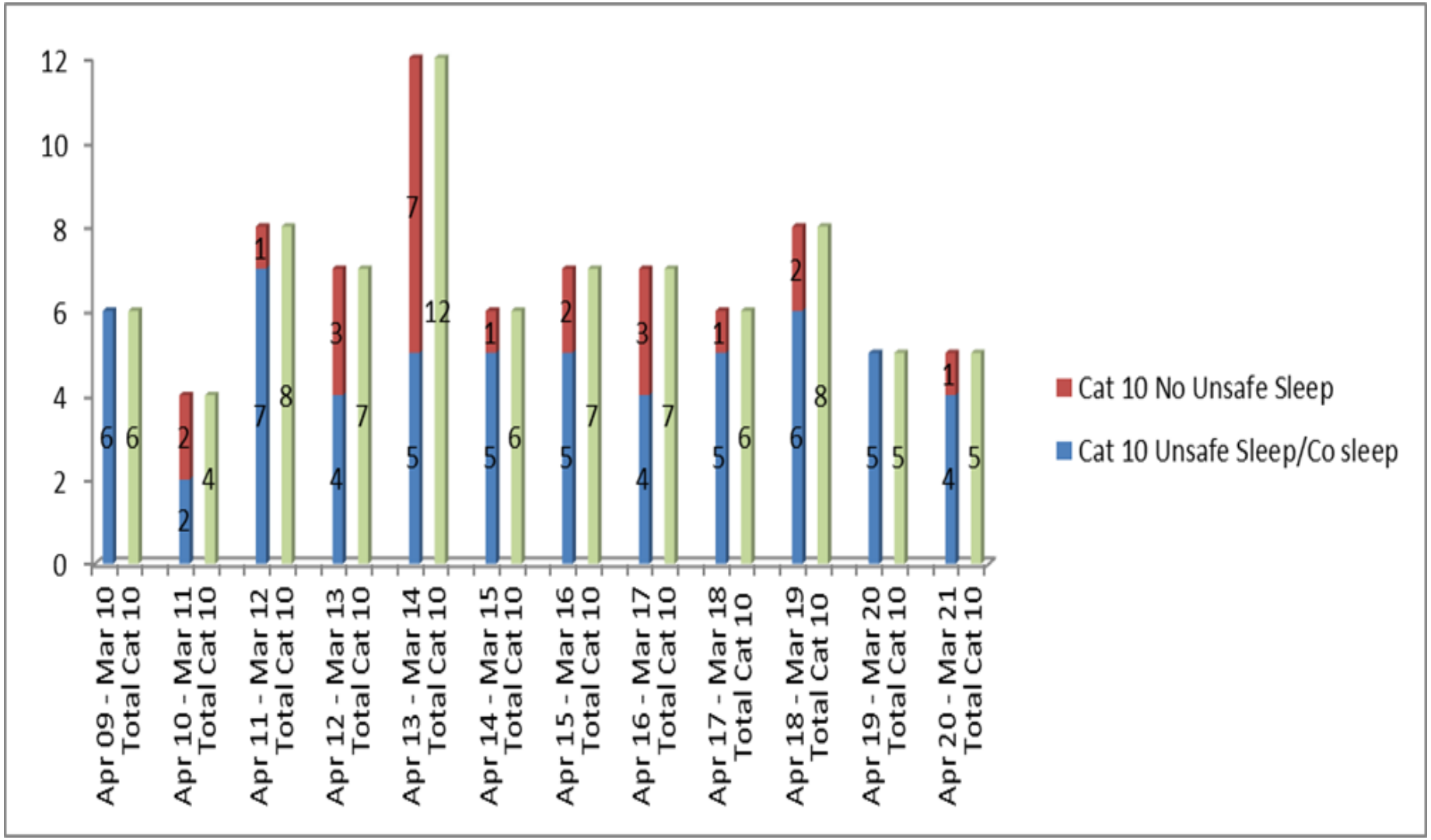
SUDIs in Nottingham/shire 1.4.09 – 31.3.21



SUDIs – explained due to neglect or trauma where death directly related to Unsafe Sleep

• Cause of Death	Circumstances
Plastic bag obstruction of upper airway	Nappy sac – mother sleeping while toddler played and baby in cot
Upper airways obstruction	Slept at grandmother's house, pillow, duvet and swaddled laying face down.
Asphyxia in an unsafe sleeping environment	Toddler sleeping bag
Positional asphyxia	Midday sleep - Trapped between double bed and wall
Hypoxic ischaemic brain injury – cause unascertained	Midday sleep – travel cot, excessive coverings, hot day
External airways obstruction	Sofa sharing with father
Accidental cause of death (overlying - related	Co-sleeping with parents in double bed
Positional asphyxiation	Fed between mother's legs on bed. Mother fell asleep

SIDS or Unexplained Deaths where Unsafe Sleep was a factor



Work Done so Far to Reduce Risk of SUDIs

- Yearly report SUDI deaths in Nottingham(shire)
- Safer sleep working group – September 15
- Communication strategy – safer sleep info based on Lullaby Trust material
- Development of Risk Assessment tool based on work done in Rotherham
- E training
- Multi agency training including launch of risk assessment tool
- ‘Where does your child wake up?’ questionnaire

More is coming……

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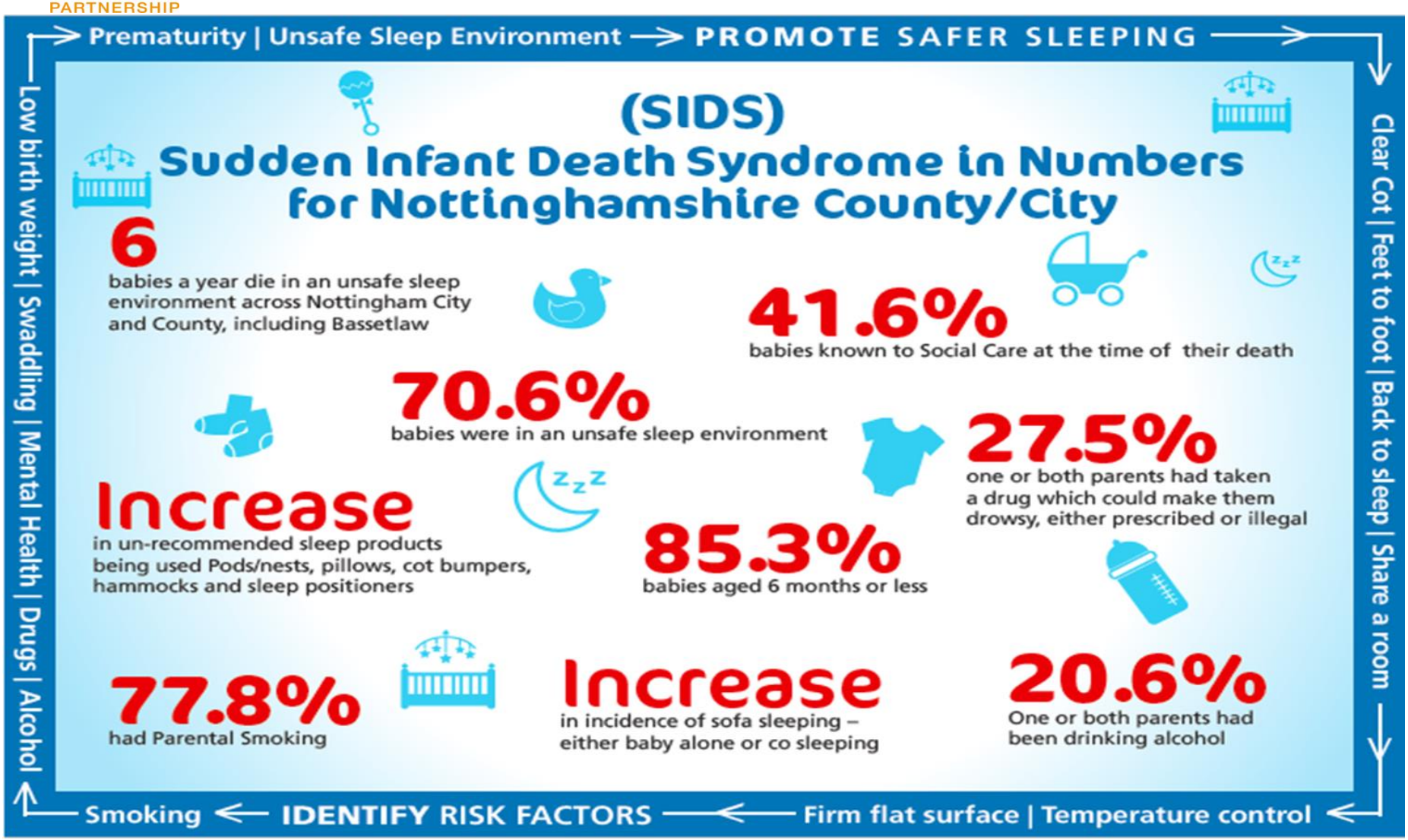
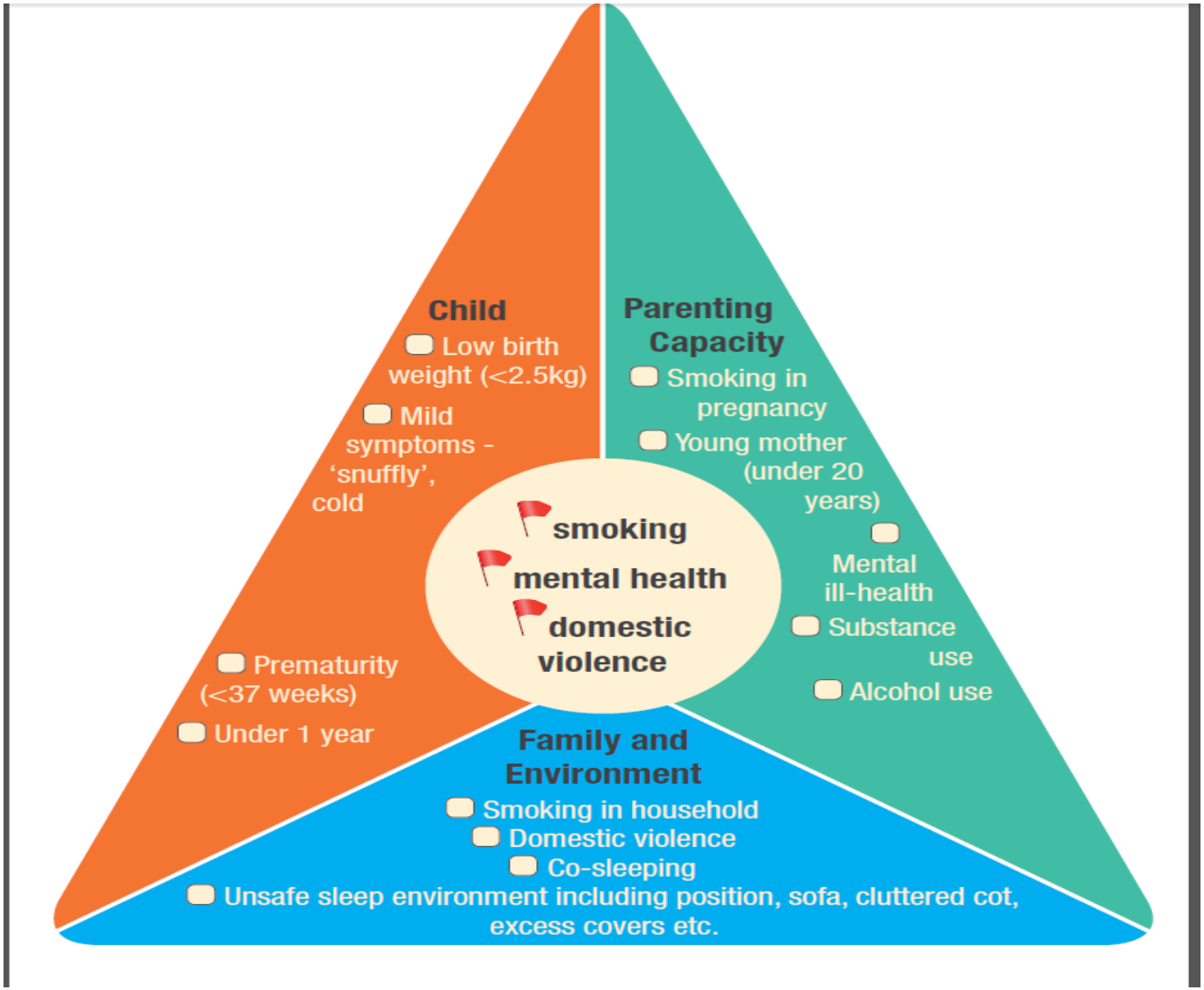


Risk Assessment Tool



Risk Factors- Smoking

- Smoking continues to be a common theme and is present in 55 (79.7%) which is an increase from last year.
- In 52 cases mother smoked in pregnancy and at time of death both an increase from last year.
- In 37 cases someone else in household smoked; in 36 cases this was father of the baby and one of these was smoking e-cigarettes.

Risk Factors- Prematurity and Low Birth weight

- Prematurity and low birth weight has been identified by the Lullaby Trust as vulnerability factors.
- In babies found in an unsafe sleep environments 26.6% were premature with low birth weight and a further 6 were normal gestation but were low birth weight.

Risk Factors- Mental Health

- Maternal mental health issues have been identified in 37 (55.6%) which is a small increase from the previous 2 years.
- On further analysis of these files, in many of the cases a history of depression/postnatal depression, low mood, self-harm, panic attacks or anxiety is described.
- Majority by Mothers but some fathers also have mental health issues.

Risk Factors- Domestic Abuse

- 39.1% had a known domestic abuse factor.
- Low numbers but we may see an increase
- In Older children domestic abuse is a safeguarding issue and not just in physical violence cases. It affects babies too.

As we know the number of people asking for help and advise around Domestic abuse has increased during COVID.

Risk Factors- Alcohol and Drugs

- Alcohol consumption has played a part in 17 cases which is 24.6%.
- Drug abuse is recorded in 18 cases which is 26.0%.
- This includes prescribed medication which reduces the person's awareness and decision making abilities.

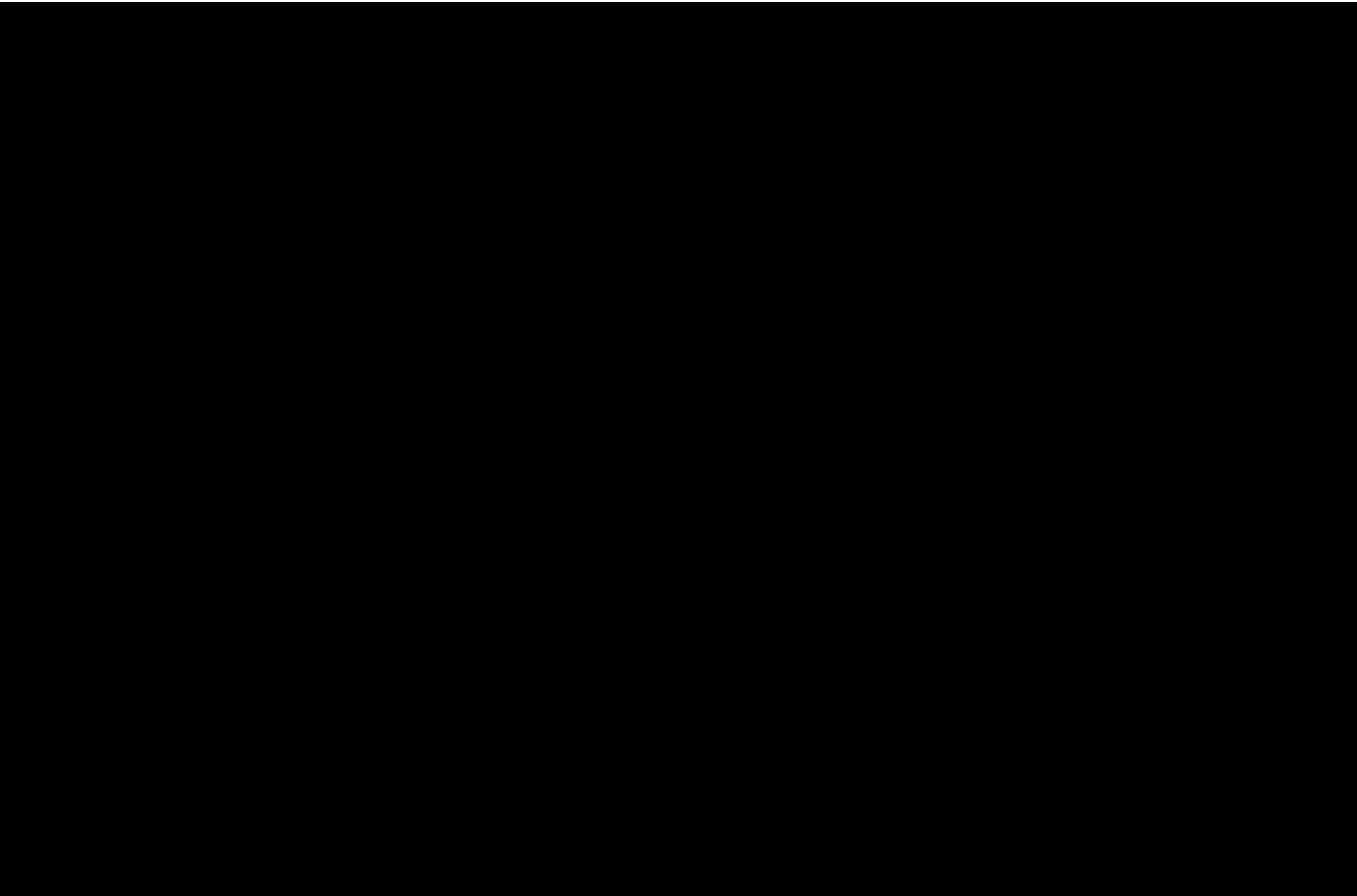
Awareness Campaign
Who's in Charge

Birmingham Community Healthcare NHS Foundation - supported by Birmingham Safeguarding Children's Partnership

http://www.lscpbirmingham.org.uk/campaigns/who-s-in-charge

This link contains x2 one minute videos highlighting the dangers of co-sleeping with your baby either on a sofa or in a bed

Video 1 – Who’s In Charge? Staying In To Drink

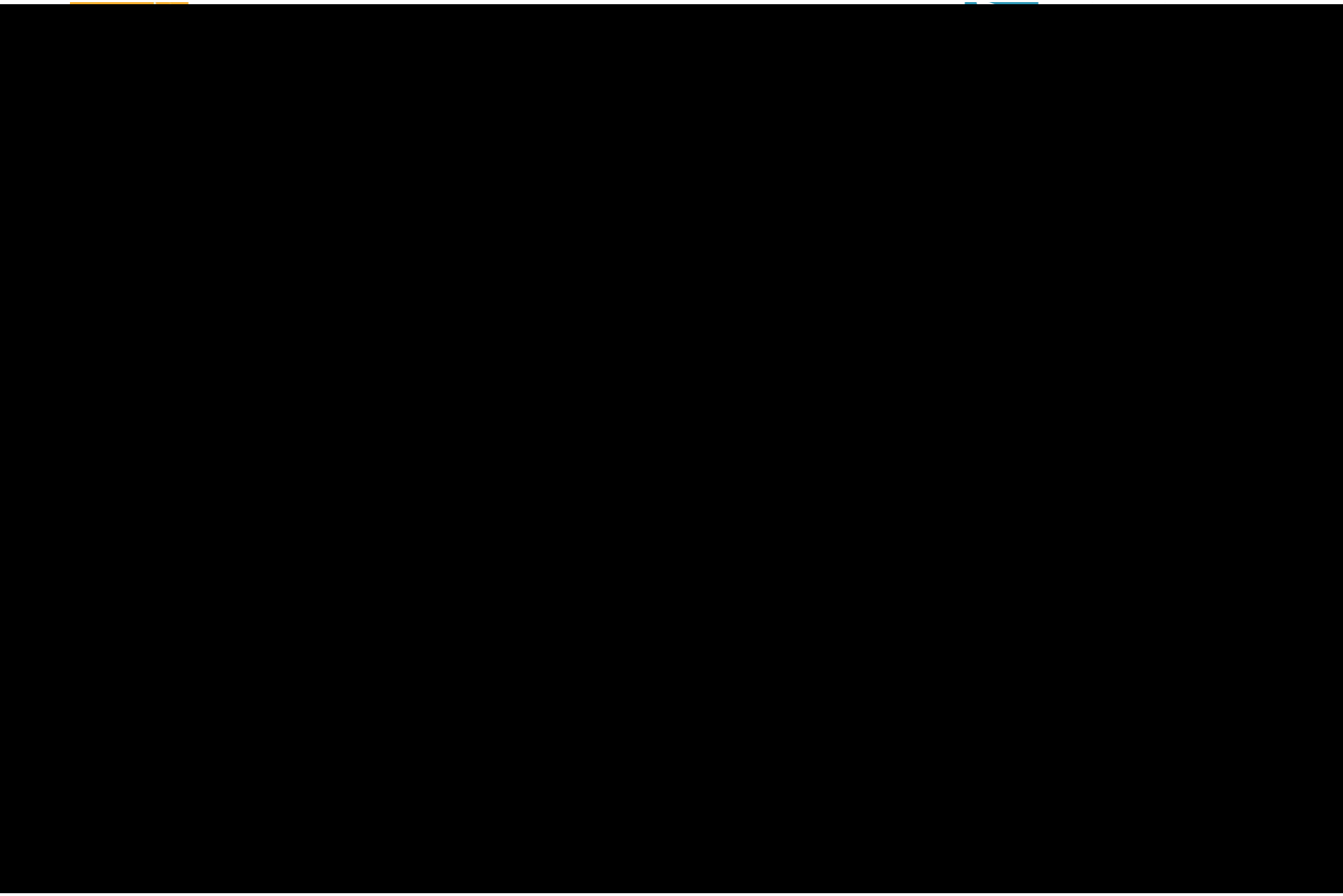


Video 2 – Who’s In Charge? Been Out For A Drink

Conclusion

- Average of 6 babies a year die in unsafe sleep circumstances which may have contributed to their deaths
- Small percentage of parents do not follow safer sleep advice-
- Risk factors such as smoking, maternal mental health issues, DV and substance misuse
- More prevalent SUDIs classified as SIDS, SUDIs (unexplained) or deaths classified as trauma due to asphyxiation.
- Need for multi agency focused work linked to reducing risk

Lullaby Trust – What Bedding Does My Baby Need?



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Questions?

Any Comments?

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BREAK

10 minutes

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National Child Safeguarding Practice Review

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

National Child Safeguarding Practice Review Panel July 2020

Mandy Smith
Children's Officer – Nottm City Safeguarding Children Partnership

Facts and Figures

- At least 300 infants die suddenly and unexpectedly each year in England and Wales
- Of the 568 serious incidents notified to the National Panel between June 2018 and August 2019, 40 involved infants who had died suddenly and unexpectedly
- Co sleeping was a feature in 38:40 cases
- This study focuses on 14 of the 40 cases covering 12 LA areas

Risk Factors Identified in the SUDI Review of Cases (Serious Incident Notifications. n=40)

- Co-sleeping (38/40)
- Parental alcohol or drug use (34/40)
- Parental mental ill health (18/40)
- Evidence of neglect (18/40)
- Domestic Violence (13/40)
- Overcrowding/poor housing (10/40)
- Parent previous criminal conviction (5/40)
- Parent care leaver (4/40)
- Young parents (2/40)

Context

- Ten families were previously receiving services under child protection, child in need plans or care proceedings
- Two families were known only to universal services before the SUDI.
- **Situational risks** and **out-of-routine incidents** were prominent - in 11 of the 14 reviewed cases the last sleep was considered out of normal routine.
- In eight cases alcohol or drug misuse was noted at the time of the last sleep.

“it is striking how each one of these deaths could have been avoided through just a bit more vigilance in following safer sleeping advice.”

Criminal Offence – Child cruelty, neglect and violence - “overlay”

- Infant under 3 years
- Cause of death is suffocation
- Infant in bed (including any kind of furniture or surface used for the purpose of sleeping)
- With another person who is over 16
- And that person is under the influence of drink or a prohibited drug

Risk Factors

Risk factors are well recognised and have formed part of clear consistent evidenced based messages for years and they have been rigorously delivered.

However, they note many of the families who are most at risk are unwilling or unable to act on them…this became the main question for the review to explore.

"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 risk of SUDI?"

Understanding Parental Decision-Making About the Sleep Environment

- Parents need advice from someone they trust and believe
- co-sleeping is both too common and too complex to apply a simple ban
- Providing parents with plausible mechanisms of harm, such as a risk of suffocation when co-sleeping on a sofa, could improve trust in safer sleep messages
- Planning for infant safety during disrupted routines might avoid rare but lethal scenarios

Solution!

- A **Prevent and Protect** practice model. Which the reviewers believe if embedded into practice has the potential to reduce risks.

- A strong view that SUDI prevention should be **seen as safeguarding work,** and not left to public health messages.

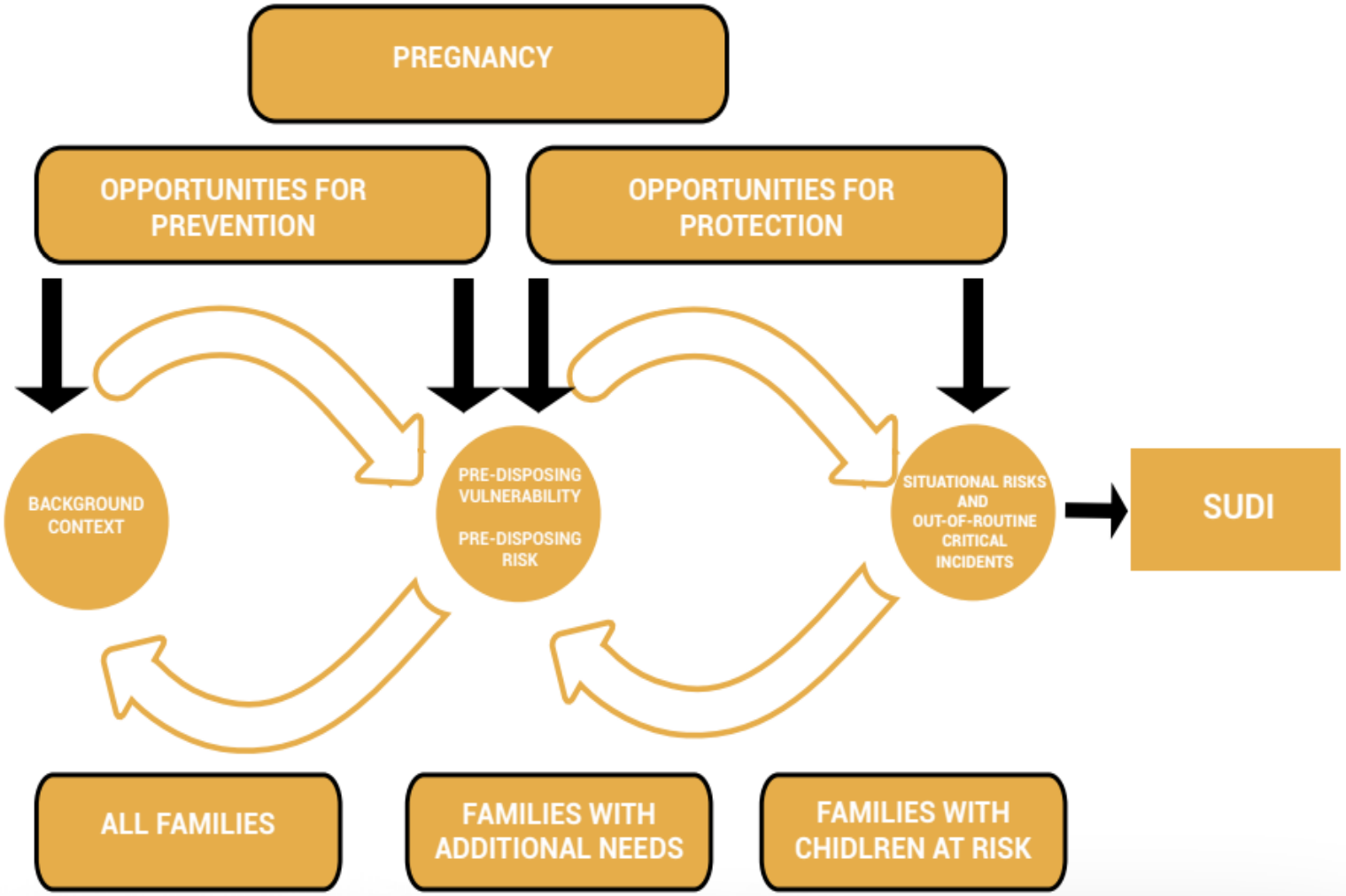
- That the work needs to be **embedded within** a respectful and authoritative relationship based **safeguarding practice**.

Response - A Prevent and Protect practice model

- Robust commissioning to promote safer sleeping within local strategy
- Multi agency action to address pre-disposing risks for SUDI with targeted support for families with additional needs.
- A differentiated and responsive multi agency practice to promote safe sleeping messages within the context of safeguarding and situational concerns.
- Underpinning systems / policies / procedures and practice tools across the continuum of risk of SUDI.

THE SUDI CONTINUUM OF RISK

The publication, 'A Review of Sudden Unexpected Death in Infancy (SUDI), July 2020 details a clear 'continuum of risk'. The diagram and table below illustrate these risks and are of crucial importance to professionals.



The SUDI Continuum of Risk

LEVEL OF RISK	FAMILIES AFFECTED	RISK FACTORS
Background context	All families	• General recognised risk factors for SUDI • Variations in access to a range of preventive services • Fragmentation between providers
Predisposing vulnerability and risk	Families with additional needs	• Socio-economic deprivation • Poor or overcrowded accommodation • Adverse childhood experience of parents impacting on inability to detect harm in interpersonal relationships • Parental mental health problems • Alcohol or substance misuse • Ongoing and cumulative neglect • Parental criminal behaviours • Relationship breakdown and/or new partners • Limited engagement with services, including late ante-natal booking and mistrust of professionals • Prematurity or other vulnerabilities in the infant
Situational risks and out-of-routine incidents	Families with children at risk of significant harm	• **Temporary housing** • **Change of partner** • **Altered sleeping arrangements** • **Alcohol or drug use**

The SUDI continuum of risk: key professionals

All families	Families with additional needs	Families with children at risk
Primary care staff (midwives, health visitors, GPs)	Children's centres, family outreach	Social workers
Stop smoking advisers, breast feeding support	Mental health workers	Early intervention workers
Housing officers, landlords	Substance misuse workers	Police and PCSOs
Benefits advice	Family Nurse Partnerships	Probation officers
		Youth offending

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What is happening Locally

Workstream within the cross authority Safer Sleep Working Group, aims:

- To embed SUDI risk reduction within a wider safeguarding context
- Equip practitioners in our workforce with the knowledge and understanding appropriate to their role to promote safer sleeping. Integrate this within a multi-agency response in families where the children are considered at risk of significant harm
- Establish and deliver a suite of ‘safer sleep’ interventions appropriate to individual families and the level of risk identified
- To understand the views of parents about safer sleep information and specifically those parents whose children are already identified as at risk of abuse or neglect

Links to resources

Safeguarding Partnership Every Colleague Matters Event

- Safer Sleeping self-directed learning session
- Safer Sleeping Risk Assessment Tool

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

- Who's in charge
- http://www.lscpbirmingham.org.uk/campaigns/who-s-in-charge

Key questions for now and to take away

In families with increased risk factors:

How can professionals best support parents to ensure that safer sleep advice can be heard and embedded into parenting practice, to reduce the risk of SUDI?

- What can you do to help?
- How can your service area begin to routinely embed ‘safer sleep’ within practice?
- How might we approach these difficult conversations with parents?