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Promoting safe sleeping and preventing sudden unexpected death in infancy:

Messages from the Child Safeguarding Practice Review Panel's national thematic review

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> Effective work is characterised by approaches that are *'personalised, culturally sensitive, enabling, empowering, relationship building, interactive, accepting of parental perspective, non-judgemental and are delivered over time'* (Pease et al., 2020, cited in Child Safeguarding Practice Review Panel, 2020, p. 31).

This short briefing shares some key messages from the **Child Safeguarding Practice Review Panel's national thematic review of sudden unexpected death in infancy (SUDI)**, published in July 2020. We hope the briefing will be useful to managers and teams across universal and targeted multi-agency early help and safeguarding in developing respectful and authoritative relationship-based safeguarding practice.

At least 300 infants die suddenly and unexpectedly each year in England and Wales and whilst overall numbers have been falling since the 1990s, sudden unexpected deaths in infancy are always devastating for families.

When we consider local policy and practice responses it is important to see the national picture. While there may only be a small number of such deaths in any one local authority, national data show areas of concern that should inform local responses. Findings from the Child Safeguarding Practice Review Panel's national thematic review of sudden unexpected death in infancy (SUDI), show that 'increasingly these deaths occur in families whose circumstances put them at risk, not just of SUDI, but of a host of other adverse outcomes' (Child Safeguarding Practice Review Panel, 2020, p. 4).

Of the 568 serious incidents notified to the Panel between June 2018 and August 2019, 40 involved infants dying suddenly and unexpectedly, making this one of the largest groups of children notified. Co-sleeping was a feature in 38 of these 40 cases. Parental alcohol and drug use were common, as were parental mental health difficulties. Additional safeguarding concerns were also present including cumulative neglect, domestic violence, parental mental health concerns and substance misuse.

The report recognises that the contexts within which these families were living meant that understanding and acting on safer sleep messages was severely challenged for a multitude of reasons, even when those messages were 'rigorously delivered' by health professionals. Issues identified included: Situational risks such as 'temporary housing, change of partner, altered sleeping arrangements and alcohol or drug use on the night in question' (Child Safeguarding Practice Review Panel, 2020, p. 21). As such, the report highlights 'the need for a flexible and tailored approach to prevention… which recognises and is responsive to the reality of people's lives' (Child Safeguarding Practice Review Panel, 2020, p. 7).

What current practices are used to reduce the risk of SUDI?

A range of interventions to reduce the risk of SUDI in families with children at risk were identified by the report including infant sleep space and safer sleep education programmes; intensive or targeted home visiting services; peer educators; health education and raising awareness interventions and targeted health education messages using digital media.

- Effective interventions were identified as being characterised by approaches that are 'personalised, culturally sensitive, enabling, empowering, relationship building, interactive, accepting of parental perspective, non-judgemental and are delivered over time' (Pease et al., 2020, cited in Child Safeguarding Practice Review Panel, 2020, p. 31).
- Strategies that were embedded within usual services, which began prior to the birth of the child and which continued after, were most effective.
- The report highlighted concerns around interventions based solely on providing information, which it found did not go far enough in bringing about change in practices. These concerns included the finding that many parents perceived safer sleeping advice as a range of options to choose from. There was also a perception that sleeping advice should be followed most of the time, rather than all of the time, with some risks being acceptable on occasion.
- Furthermore, any strategy which incorporates the dissemination of information to families should take note of feedback from parents included in the report which highlighted inconsistencies in safer sleep messages particularly around bed sharing. Also identified as unhelpful were leaflets that were text heavy and those that were 'poorly photocopied in black and white' (Child Safeguarding Practice Review Panel, 2020, p. 26).
- Unsafe sleep environments which increase the risk of SUDI include 'co-sleeping in the presence of other risks (including bed sharing), overwrapping (head covered, use of pillows or duvets)' and 'soft sleep surfaces (soft or second-hand mattress)' (Child Safeguarding Practice Review Panel, 2020, p. 18).
- Some preventative interventions have combined risk reduction approaches with the provision of safer sleeping spaces for babies, such as bassinettes. Positive initiatives include **the baby box programme launched in Scotland in 2017** which is modelled on the Finnish baby box introduced in the 1930s. In New Zealand, work on safe sleeping has built upon the Maori-led SUUDI prevention initiative developed in 2005 which uses the Wahakura (a traditional Māori woven basket) and the Pēpi-Pod as safer sleep devices (as seen on the cover of this briefing). There is some evidence from New Zealand that these interventions have contributed to a reduction in infant mortality (Mitchell et al., 2016; Cowan, 2015). Studies showed that 'the majority of recipients did use the sleep space provided, immediately reducing the risk of the need to bed-share or use an alternative hazardous sleep environment' (Pease et al., 2020, cited in Child Safeguarding Practice Review Panel, 2020, p. 31).

- The report emphasises that out-of-routine situations – such as staying with family or friends, or following a party where there is alcohol consumed – can increase the risk of bed sharing or sofa sleeping. Therefore focusing safer sleep conversations and information on risk situations, including conversations about sleeping arrangements in such out-of-routine circumstances, are important for ensuring a safe sleep environment for infants.
- Findings showed that parents are more likely to act on advise they receive from someone they trust and believe. And so, whilst the report acknowledges the challenges associated with improving the engagement of vulnerable families, the importance of relationship-based approaches to practice, which emphasise building trusting relationships over time, are highlighted as critical to effective practice.

Recommendations from the Child Safeguarding Practice Review Panel's report

The report calls for a new multi-agency approach to SUDI prevention that embeds it in 'respectful and authoritative relationship-based safeguarding practice' (Child Safeguarding Practice Review Panel, 2020, p. 5). SUDI prevention is not something that can be left to public health practitioners alone, but should be understood as part of broader safeguarding work including policies for responding to social and economic deprivation, housing need, domestic violence and parental mental health concerns. Also called for by the report are new government tools and processes to support practitioners to incorporate this new approach.

The report proposes a 'prevent and protect' practice model, which the authors say has the potential to improve the way services work with families with children at risk of significant harm (Child Safeguarding Practice Review Panel, 2020, pp. 40-42). The model explicitly acknowledges that there is a continuum of risk of SUDI, and says support and interventions should be differentiated and graded to reflect the needs of: (i) all families; (ii) families with additional needs; and (iii) families whose children are at risk of significant harm.

As research evidence suggests that underlying social and environmental factors may have an effect on SUDI independently of risks such as low birth-weight or smoking in pregnancy, the model includes socioeconomic deprivation, overcrowded housing and adverse childhood circumstances within the pre-disposing risks of SUDI.

Safeguarding partners, working with commissioners and other local providers, can use the model to develop more flexible strategies for reducing the risk of SUDI across the local population. For families with children at risk of significant harm, this will not only reduce the risks of SUDI but will help also to address 'a much wider range of risks to children's health, safety and development' (Child Safeguarding Practice Review Panel, 2020, p. 4).

The model proposes that safer sleep advice and risk assessment are joined up with wider safeguarding considerations and plans to work with families. In particular, the promotion of safer sleeping advice and the identification of unsafe sleep environments should be directly linked to local strategies for responding to neglect, reducing domestic violence, tackling substance misuse and addressing parental mental health difficulties.

Fieldwork cases examined for the report highlighted the importance of existing risk assessment processes in the context of promoting safe sleeping. Child protection conferences, care plan meetings and review team meetings all provide opportunities for social workers or independent reviewing officers to review judgments about risk, for example.

Reflective questions for local safeguarding partners

The *Child Safeguarding Practice Review Panel Report* (2020) includes reflective questions designed to help local partners appraise how well current provisions measure up to the 'prevent and protect' practice model outlined in the report (Child Safeguarding Practice Review Panel, 2020, p. 43). These reflective questions are summarised below:

1. **Understanding the views of parents**
   Are the views of parents about safer sleep information (format, accessibility, timing, key messages and 'conversations' with practitioners they trust and believe) understood and integrated with messages around normal infant care and safety?

2. **Knowledge, understanding and skills of the workforce**
   Do practitioners in our workforce have the right knowledge and understanding appropriate to promote safer sleeping? Does this role form part of a multi-agency response, and if so how is it integrated?

3. **Multi-agency systems and processes**
   How is the risk of SUDI, and un-safe sleeping arrangements in particular, incorporated into multi-agency safeguarding procedures and practice tools for responding to other safeguarding concerns?

4. **Workforce capacity**
   Is workforce capacity adequate in order to support parenting (including safer sleep advice) in families with additional needs and for families experiencing challenges that leave them vulnerable? If not, how can sufficient support be provided within the constraints?

5. **Quality assurance**
   What measures need to be in place to assess the effectiveness of work to promote safer sleeping and reduce the risk of SUDI?

Conclusion

An unexpected infant death is devastating for any family to experience. That many of these deaths are preventable is a further tragedy. This 2020 report by the Child Safeguarding Practice Review Panel shines a light on the disproportionate number of these deaths which occur in families living with challenging circumstances, highlighting that messages around safer sleeping are currently not effective either in reaching, or being taken up by, the most vulnerable families. Effective multi-agency strategies, based on knowledge of the views of parents about safer sleeping information, and tailored to the needs and circumstances of individual families, with a particular focus on families with children at risk, are now needed to promote safer sleeping and reduce the risk of SUDI.

Further information and guidance to support practice

Organisations such as Unicef (www.unicef.org) and The Lullaby Trust (www.lullabytrust.org.uk) have produced guidance for professionals to support them in discussions with parents around co-sleeping and SUDI.

Unicef – Co-sleeping and SIDS: A guide for health professionals

The Lullaby Trust – Safer sleep: Saving babies lives a guide for professionals

A range of accessible information leaflets to support parents are also available from the Lullaby Trust:

The Lullaby Trust – Safer sleep for babies: a Guide for Parents

The Lullaby Trust – Safer Sleep Advice for Premature and Low Birth Weight Babies booklet

The Lullaby Trust – Safer Sleep for Babies quick reference card

The Lullaby Trust – Safer Sleep for Babies Easy read card

The guides above by the Lullaby Trust are also available in **23 additional languages**.

Further reading

Related resources from Research in Practice

Baynes, P., Bowyer, S., & Godar, R. (2019). *Neglect in the context of poverty and austerity: Frontline Briefing*. Research in Practice.

Bywaters, P. (2014). *Child poverty: The role of children's services: Leaders' Briefing*. Research in Practice.

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Child Safeguarding Review Panel (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*. Department for Education.

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Cowan, S. (2015). T*heir First 500 Sleeps. Pepi-Pod Report: 2012-2014*. Change for our Children Limited.

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Mitchell, E.A., Cowan, S., & Tipene-Leach, D. (2016). The recent fall in post-perinatal mortality in New Zealand and the Safe Sleep programme. *Acta Paediatrica*, *105*(11), 1312-1320.

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Available from:
https://research-information.bris.ac.uk/en/publications/systematic-literature-review-report-for-the-national-child-safegu

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