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First ever study of serious case reviews of sudden unexpected infant deaths conducted

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For the first time in England a study has been conducted of official investigations of unexpected infant deaths.

The research was conducted by academics at the University of Warwick who aimed to develop a detailed understanding of the circumstances of sudden unexpected death in infancy (SUDI) cases subject to serious case review.

The team, led by Dr. Joanna Garstang from the Division of Mental Health and Wellbeing, Warwick Medical School, found that most SUDI cases occurred in hazardous sleep environments and are potentially preventable. They also found that they occurred in families well known to services with concerns about neglect, substance misuse and poor engagement.

Sudden unexpected death in infancy (SUDI) remains a significant problem with around 300–400 SUDI cases annually in England and Wales. SUDI is defined as the sudden and unexplained death of an infant that had not been considered as a reasonable possibility in the previous 48 hours.

The cause of death remains unexplained in approximately two-thirds of SUDI cases, and these are often categorised as sudden infant death syndrome (SIDS). Potentially modifiable risk factors for SIDS are well established, including parental smoking, the infant sleeping face-down or on its side, and co-sleeping with a parent who has consumed alcohol or

drugs. However, SIDS has declined dramatically since the 1990s following safe sleep campaigns, and now occurs largely in association with social deprivation and modifiable risk factors.

The paper, "Qualitative analysis of serious case reviews into unexpected infant deaths," examined serious case reviews in England from April 2011 to March 2014.These were cases of infants aged zero to two, for whom no clear medical or forensic cause of death was found. Serious case reviews (SCRs) are held to improve the way professionals and agencies work individually and collectively to safeguard and promote the welfare of children. SCRs are not enquiries into how a child was harmed or died, or who was responsible; these issues are for police and coroners

The researchers gained access to 27 out of the 30 reviews that were held during the time period. They found that in 18 cases, parents did not engage with professionals, 18 families suffered alcohol or drug dependency, there were 14 cases of parental mental health problems, in 13 cases, parents had criminal records, and there were nine cases of domestic abuse.

The analysis of the 27 reviews also highlighted that 18 deaths occurred in highly hazardous sleep environments; 16 of those involved co-sleeping, and 13 of those occurred with parents who were drunk or had taken drugs.

Dr. Garstang's said the research found that long standing neglect was a prominent feature in 15 of the 27 cases: "Eleven families' siblings were reported as dirty, hungry, inadequately dressed or had severe dental caries, and seven families lived in homes described as squalid. Four mothers lacked basic parenting skills, and one father was convicted for child neglect after leaving his young children home alone."

Jenny Ward, director of services at the Lullaby Trust, said, "We

welcome this study, which demonstrates the urgent need to ensure safer sleep advice reaches all parents and carers, particularly vulnerable families where extra support is often most needed. While reaching vulnerable parents can be challenging, the study shows that it could ultimately save babies' lives."

The paper, which is published in the *Archives of Disease in Childhood*, concluded that more consideration is needed on how best to support such vulnerable families. Dr. Garstang added: "A remaining challenge is how to deliver safe sleep messages to high-risk families who may be hard to reach. Despite 25 years of safe sleep campaigns, some parents are still not receiving, not hearing, not understanding, or choosing not to follow this advice, resulting in many infants being exposed to hazardous sleep situations. Future research needs to focus on how best to support and engage with these vulnerable families."

More information: Joanna J Garstang et al. Qualitative analysis of serious case reviews into unexpected infant deaths, *Archives of Disease in Childhood* (2018). DOI: 10.1136/archdischild-2018-315156

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