Support frontline workers to engage parents struggling with safer sleeping advice

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The Government needs to develop new tools to help prevent the sudden unexpected death of infants (SUDI), says a new review by the Child Safeguarding Practice Review Panel which included University of Bristol researchers.

The independent panel of experts reviews serious child safeguarding incidents, when children have died or suffered serious harm, to learn how to improve the safeguarding system.

While the overall numbers of babies dying from SUDI are decreasing, a worrying number of deaths have been notified to the Panel as serious child safeguarding incidents. Between June 2018 and August 2019, the deaths of 40 babies from SUDI were reported to the Panel. Most of whom died after co-sleeping in bed or on a chair or sofa, often with parents who had consumed drugs or alcohol.

The review reveals families with babies at risk of dying in this way are often struggling with several issues, such as domestic violence, poor mental health or unsuitable housing. It found that these deaths often occur when families experience disruption to their normal routines and so are unable to engage effectively with safer sleeping advice.

Due to COVID-19 and the associated anxieties about money, social isolation and mental health issues, disruptions that led to the deaths of these infants may be more prominent at present.

To address this, the Panel is calling for local areas to reduce the risk of SUDI by incorporating it into wider strategies for responding to social and economic deprivation, domestic violence and parental mental health concerns. This should be backed up by new Government tools and processes to support frontline practitioners and local safeguarding partners to make these changes.

Interim Chair of the Child Safeguarding Practice Review Panel, Karen Manners QPM said: "The unexpected death of an infant is a tragedy and although it's not always predictable, some babies appear to be more at risk.

"Families with children at higher risk of SUDI are often struggling with several issues, such as domestic violence, poor mental health or unsuitable housing, and infants may die after co-sleeping on a sofa or with parents who have consumed drugs or alcohol.

"Therefore, it's vital that practitioners work together to help parents understand how to make sure that every sleep is a safe one for their baby."

Leading SUDI expert and Child Safeguarding Practice Review Panel Member, Prof Peter Sidebotham said: "It's important that we give all families information about safe sleeping, but for some families who are struggling with multiple issues the existing information is simply not enough.

"This is not about blaming parents who have suffered such tragedies. This is a societal issue and we need to listen to and talk with families realistically and honestly so we can make sure that their babies sleep safely all the time."

Chief Executive of The Lullaby Trust, Jenny Ward said: "This review

highlights that safer sleep, despite being the best way to reduce the risk of SUDI, is not always easy to follow. We need to identify the families who require additional support to help make decisions that are right for them and their baby, particularly when faced with an unexpected situation such as when your baby is unwell or you are staying away from home.

"Despite great reductions in SUDI rates over the past few decades there is still a lot of work to be done, and we know the devastation the death of a baby has on families. We welcome the recommendations and look forward to sharing our learning and knowledge around communicating with families to prevent more babies from dying."

Lead author of the literature review and Senior Research Associate at the University of Bristol, Anna Pease said: "Our review highlighted the importance of understanding how safe sleep messages are interpreted and acted on by families with vulnerable babies.

"We know that babies are more at risk when the normal routine is disrupted and families need extra support during those times. Support given to families must acknowledge the adverse effects on parents from lack of sleep when looking after a young baby and professionals must work with parents and carers to find realistic solutions that keep babies safe while they sleep.

"We hope that our findings and the implementation of the recommendations from this report will prevent more infants' lives being lost. Whilst our study predated the COVID19 pandemic the additional stresses on vulnerable families during the pandemic are likely to make such support even more important."

The review examines the deaths of 14 babies from 12 local areas to understand how professionals can best support parents to ensure that

safer sleep advice is heard and embedded.

The findings show:

- Families living within a context of recognised background risks, such as deprivation and overcrowding, domestic violence or poor mental health, are at heightened risk of losing a baby to SUDI. All those working with families need to recognise that and work together—this is not just an issue for midwives and health visitors.
- We need a flexible and tailored approach to prevention that is responsive to the reality of people's lives. That means talking honestly with parents about how they will cope in different situations to ensure every sleep is safe.
- The best local arrangements for promoting safer sleeping involve a range of professionals as part of a relationship-based programme of support, embedded in wider initiatives to promote infant safety, health and well-being.
- A prevent and protect practice model should be locally adopted to recognise the continuum of risk of SUDI, with support and interventions that are graded to reflect the needs of different families.

The review makes the following recommendations for the Department for Education, Department of Health and Social Care, Home Office and Public Health England:

- To develop shared tools and processes to support front-line professionals from all agencies in working with families with children at risk to promote safer sleeping as part of wider initiatives around infant safety, health and well-being.
- To work with the National Child Mortality Database to explore how data collected through child death reviews can be cross-

checked against those collected through serious incident notifications.
- To embed learning from this review as part of the refresh of the high impact areas in the Healthy Child Programme and the specification for health visiting.

The review also recommends that further practice-based research is undertaken to establish the efficacy of different interventions to reduce the risk of SUDI and into the use of behavioural insights and models of behaviour change. The Panel is exploring options to commission this research and is interested in hearing from organisations to partner on this work.

The Panel's annual report shows that babies are most at risk of serious harm and death from abuse and neglect. Therefore, it is undertaking a further in-depth review into the non-accidental injury of infants under one year old.

Provided by University of Bristol