Although a formal committee of Brighton & Hove City Council, the Health & Wellbeing Board has a remit which includes matters relating to the Clinical Commissioning Group (CCG), the Local Safeguarding Board for Children and Adults and Healthwatch.

Title:	Responding to the National Child Safeguarding Review Panel 'Out of Routine report' on Sudden Unexpected Death in Infancy	
Date of Meeting:	24 March 2020	
Report of:	Director Public Health	
Contact:	Sarah Colombo	Tel: 07827233577
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Wards Affected:	All	

FOR GENERAL RELEASE

Executive Summary

This paper describes the national report and local response to sudden unexpected death in infants. There is a strong body of evidence around the importance of addressing the factors that can contribute to sudden unexpected death in infants and this paper outlines a Sussex-wide response that encompasses a universal offer and targeted work with vulnerable families. This paper also outlines the work to date across Sussex on the ICON programme which focuses on infant crying and coping strategies for parents and carers. Dr Jamie Carter Designated Doctor for Safeguarding Children for Brighton and Hove will deliver a presentation at the Board detailing aspects of this paper.

1. Decisions, recommendations, and any options

1.1 That the Board note the report.
1.2 That the Board agrees this is a key message for all frontline practitioners working with parents, carers and families and should be 'Everybody's Business'.

2. Relevant information

2.1 Background

2.1.1 The National Child Safeguarding Practice Review Panel's report 'Out of Routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm' published in July 2020 details the factors involved in these tragic deaths.

2.1.2 The report's executive summary outlines the reason for the review,

> 'Infants dying suddenly and unexpectedly represent one of the largest groups of cases notified to the Panel, with 40 notifications between June 2018 and August 2019. While these represent only a proportion of all SUDI, they occur in families who are particularly vulnerable and each one is a devastating loss for the family. Almost all of these tragic incidents involve parents co-sleeping in unsafe sleep environments with infants, often when the parents had consumed alcohol or drugs. In addition, there were wider safeguarding concerns – often involving cumulative neglect, domestic violence, parental mental health concerns and substance misuse'

2.1.3 The report has three recommendations two of which concern actions at a national level around improving data analysis and the development of shared tools and processes for frontline practitioners. Recommendation 2 focuses on the importance of embedding knowledge and expertise around safer sleeping practices in a range of frontline services working with parents, carers, and families. In effect to develop the understanding that safer sleeping is 'Everybody's business'.

2.2 Recommendation 2 of the SUDI report

2.2.1Recommendation two focuses on the role of health visiting services and the importance of all frontline practitioners that work with families having a clear understanding of the issue,

> 'We recommend that, as part of its refresh of the high impact areas in the Healthy Child Programme and the specification for health visiting, Public Health England considers how the learning from this review could be embedded within the transition to parenthood and early weeks. In particular, to consider how targeted multi-modal interventions that provide a safe infant sleep space with comprehensive face-to-face safe sleep education can be

embedded in wider whole family initiatives to promote infant safety, health and wellbeing; and to consider how the implementation of these elements of the Healthy Child Programme can be expanded to involve practitioners from all agencies working with families with children at risk.'

2.3 The Impact of COVID on young children

2.3.1 The Child Safeguarding Practice Review Panel's December 2020 practice review, 'Supporting Vulnerable Children and Families during COVID-19' identified parental and family stressors as,

> 'major factors across the full range of cases involving COVID-19. Increasing domestic violence and mental health concerns were key features across the Rapid Reviews. The lack of contact with extended family members during lockdown meant the loss of a key protective factor in some cases.'

and the report went on to note,

> 'Harm to babies under 12 months old
> Babies under 12 months old continue to be the most prevalent group notified, and there were a high proportion of cases involving non-accidental injury and sudden unexpected infant death. In these cases, parental and family stressors were the most significant factor in escalating risk.'

The Child Safeguarding Practice Review Panel, 'Supporting Vulnerable Children and Families during COVID-19 Practice Review' Dec 2020

2.3.2 Additional COVID-19 pressures on families;

- Support networks not accessible
- Self-isolation with children and potentially at risk adults
- Concerns increased around young babies and parents in lockdown
- Children not presenting at health settings
- Families not accessing group and professional contacts
- Loss of income
- Social distancing restrictions on activities which might lessen stress (e.g. sports, social engagement and entertainment, celebrations)

2.4 A Sussex wide response

2.4.1 A multi-agency Sussex wide Community of Practice group was initiated in November 2020 and has met three times to discuss the findings of the report within the context of Health Visiting services in Sussex and the wider multi-agency landscape of services working with vulnerable families where children are identified as at risk.

2.4.2 This Sussex wide approach, supported and promoted by the three Sussex Safeguarding Children Partnerships will build upon the very successful ICON programme aiming to create;

- A tiered response that aims to create a coherent pathway from universal to targeted/specialist services with a strong consistent message and an approach that invites all services involved with families to see safer sleeping as 'Everybody's business'.

- A response that aligns the Safer Sleeping with the messaging and training already in place across Sussex around ICON (safer strategies for parents dealing with crying babies) and a broader objective of developing more effective methods for engaging fathers and partners in accessing information and support.

- An online survey has been delivered across Sussex following a review of research and best practice in engaging with fathers and non-birthing partners around parenting information and support. Two thirds of fathers and non-birthing parents who completed the survey said they look to their partner for information but that they would use an online app designed for fathers and non-birthing parents if it were available.

2.5 The aim

2.5.1.Universal and Early Help
Review the current information and materials around safer sleeping practices across all three areas with the aim to agree a consistent set of messaging and information for parents and practitioners across Sussex.

2.5.2 Delivery of a set of short webinar workshops to a range of frontline professionals aimed at improving knowledge of safer sleeping and developing consistency of approach to the issue across services such as Children's Centres, Early Years provision, Voluntary and Community Sector organisations working with families, Health Services, Fire & Rescue Services, the Police.

2.5.3 Multi-agency work with vulnerable families where children are at greater risk. Deliver workshop webinars to engage managers and frontline practitioners working in services that engage and support vulnerable families such as Children's Social Work, Primary Care, Housing, Children's Centres, Health Visiting, specialist drug and alcohol services and those working with families where domestic abuse and violence is taking place. The aim of these workshops will be:

- to ensure there is a consistent message and understanding of the additional risks to children of unsafe sleeping practices in families where the landscape of family life includes one or more of the risk factors outlined above.

- to provide additional information and practical ideas to improve identification of safe sleeping issues and the practitioner response including working with fathers and partners.

2.6 The ICON Programme in Sussex

2.6.1 The ICON Programme is a preventative programme, based around helping parents cope with a crying baby. Conceived by Dr Suzanne Smith PhD who undertook research in USA and Canada in 2016 into the study of effective interventions and research into the prevention of Abusive Head Trauma (AHT/ Shaken baby).
ICON is an evidence based programme consisting of a series of brief 'touchpoint' interventions that reinforce the simple message making up the ICON acronym. It also incorporates a 'safe sleep' message. Hampshire Safeguarding Children Partnership worked with Sue Smith to develop a programme for ICON in the UK.

2.6.2 The goal for ICON is to communicate to parents/carers that;
- They can expect and understand crying
- They can prepare for crying
- They have some strategies to cope with crying

2.6.3 ICON Programme achievements in Sussex

- Each area has a multi-agency ICON steering group driving embedding messages and operational engagement with the ICON materials and support
- Pan-Sussex awareness via Safeguarding Children Partnerships & health safeguarding routes
- Maternity services adoption
- Children's Social Care & Community & Voluntary Sector in Brighton & Hove
- ICON training to primary care and providers
- In Brighton & Hove strong link from ICON to the Reducing Parental Conflict Programme
- Community of Practice Sussex wide group established to develop approaches to working with fathers and non-birthing partners

3. Important considerations and implications

Legal: The report demonstrates how the local authority in conjunction with its' partners will work together on a multi-agency basis to meet its' statutory duties and powers to support vulnerable families and safeguard babies in the locality who require protection from the risks of SUDI.

Lawyer consulted: Date:12/03/21
Hilary Priestley Senior Lawyer

Finance:
There are no additional costs arising from the proposals contained within this report. The recommendations are around improving practice, awareness and training with staff already in funded roles to undertake this work.

Finance Officer consulted: Date: 12/03/21
Louise Hoten Head of Health, Adults, Families, Children and Learning Finance

Supporting documents and information

Appendix1:

National Child Safeguarding Practice Review Panel report 'Out of Routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm'. July 2020

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

ICON National website
ICON - Babies cry you can cope - Advice and Support | ICON (iconcope.org)

Brighton & Hove Safeguarding Children Partnership – ICON webpages
ICON - Share the message - BHSCP

National Child Safeguarding Practice Review Panel report: Supporting vulnerable children and families during COVID-19 (mcusercontent.com)
Practice briefing. December 2020