

Sudden Unexpected Death in Infancy (SUDI) Review

November 2021

<h3>1. Purpose of the SUDI Review</h3>
<p>The Merton Safeguarding Children Partnership (MSCP) received a recommendation from a Joint Agency Response (JAR) Meeting to undertake a Partnership Review on two cases of Sudden Unexpected Death in Infancy (SUDI). Although the Local Authority concluded that neither of the SUDI cases met the criteria for a Serious Incident Notification, the JAR identified that there could be learning for multi-agency partners from both cases. The review sought to identify any relevant learning for the MSCP and recommendations for improved practice.</p> <p><i>(Chapter 4 (Paragraph 19) of Working Together 2018 makes the provision for local areas to undertake practice reviews where statutory thresholds have not been met (for example, where there has been poor practice, good practice, or there has been a 'near-miss')</i></p>
<h3>2. Methodology</h3>
<p>The review took the form of two learning events, chaired by an independent lead reviewer, Kerrie Scraton. These used Appreciative Inquiry approaches to identify learning from the findings of the cases. Agencies were also asked to provide their own brief chronologies and overview of learning in advance of these sessions. Agencies who attended the events included: Police, Children's Schools and Families (children's social care and early help teams), health partners including representatives from CCG, CLCH, Southwest London and St George's NHS Trust, and General Practice. Housing was invited but did not attend; Housing colleagues confirmed that neither baby was known to their services. Agencies involved agreed that it was not an appropriate time to reach out to the families and therefore their feedback was not sought as part of the review.</p>
<h3>3. Learning Points</h3>
<p>The Chair, along with the agencies involved, agreed that these deaths could not have been prevented. However, the sessions identified some pertinent learning for multi-agency partners, which would be important to share to reduce risk in the future.</p> <p>What worked well:</p> <p>When discussing what worked well, the group reviewed common risk factors for SUDI, identified by national research¹, including:</p> <ul style="list-style-type: none"> ▫ <i>Unsafe sleep position (prone or side)</i> ▫ <i>Unsafe sleeping environment (co-sleeping, overwrapping, soft sleeping surfaces etc.)</i> ▫ <i>Tobacco (pregnancy and environmental exposure)</i> ▫ <i>Alcohol and drugs (during pregnancy and when co-sleeping)</i> ▫ <i>Poor post-natal care (late booking and poor ante-natal attendance)</i> ▫ <i>Low birth weight (under 2,500g) and pre-term birth (less than 37 weeks' gestation)</i>

¹ [Out of routine: A review of sudden unexpected death in infancy \(SUDI\) in families where the children are considered at risk of significant harm \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

- Health visiting services and children's social care confirmed that both families were provided information regarding safe sleeping and in both cases the health visitor had established good relationships with mum. Other services have been offered and taken up, such as programmes for addressing smoking and drinking alcohol.
- Birth weights were considered for both babies and both were monitored for weight gain; one baby initially had low birth weight but was progressing well. Routine enquiries for both babies were carried out appropriately by health agencies.
- Overall, agencies identified good information sharing and decision making. However, for Baby J, the Children and Families Hub could have completed additional agency checks with Hull Social Care and Housing to establish any past concerns and current interventions.

Areas in need of system development:

1. There could have been improved links between Children, Schools and Families (CSF) and Housing to ensure that Baby J's family received earlier and more proactive support when experiencing or at risk of experiencing homelessness or overcrowding. It is important that Children's Services pursue the need for housing support for families experiencing homelessness as per Section 27 of the Children Act and the 'duty to refer' as per the Homelessness Reduction Act 2017. A Section 17 assessment should have taken place in the case of children becoming homeless.
2. A mutual understanding needs to be developed regarding how to support Housing in understanding the socioeconomic impact of poor housing on families, especially mothers and babies. The review highlighted that, historically, women under the care of midwives have not been supported by Housing with their individual needs.
3. Merton's Early Help services, midwifery, health visiting and the Children and Families Hub (formerly MASH) could have worked more closely together to ensure that the families were able to access earlier support. Both families should have been considered for early help support, through referrals from either universal services, or from the Hub, as their living situations were unsettled
4. The Children and Families Hub (formerly MASH) needs to ensure that agency checks, both with Merton and other local authorities, are completed and obtained in a timely manner to establish past concerns about a family and current intervention. In the case of Baby J, there is no record of Hull Social Care and Housing having been contacted. Local agency checks were not obtained until after Baby J's passing.
5. There could have been more professional curiosity from Health Visitors/Midwives regarding the home environment of a family. The usual pathway is for mothers to disclose information before it is followed up, unless there is suspicion about the information given.

4. Next Steps/Recommendations

1. Children, Schools and Families (CSF) and Housing should consider how they can improve joint working to support families experiencing or at risk of experiencing homelessness. They should consider co-locating a Housing Worker in the Children and Families Hub.
2. (a) The MSCP should seek assurance that agencies recognize the impact of poor housing on families, especially mothers and babies, and raise with Merton Housing/placing Local Authority.

(b) The MSCP to take action to raise awareness across the Partnership on issues of poor housing and homelessness, and the impact this has on safeguarding children and families by:
 - Signposting information about the impact of poor housing and homelessness on safeguarding children and families on the MSCP website and in the news bulletin

- Policy and Training sub-group to consider commissioning training or briefings on the impact of poor housing and homelessness on safeguarding children and families
- 3. Children, Schools and Families (CSF) division to undertake a review of the effectiveness of Early Help and the Children and Families Hub in dealing with issues of homelessness. This review will then be fed back to the MSCP for assurance.
- 4. The MSCP should seek assurance from Children's Social Care that agency checks are carried out in a timely manner, especially when families have moved to Merton from another local area.
- 5. The MSCP to seek assurance from CLCH, St Helier and St Georges Hospitals that they are addressing areas of improvement identified around lack of professional curiosity, especially in relation to midwives and health visitors when assessing the home environment of a family.
- 6. The MSCP to provide and promote information and training around the risk factors relating to SUDI identified nationally (e.g., co-sleeping, sleep positions, tobacco, alcohol and drugs, post-natal care and birth weight) By:
 - Raise awareness of Safe Sleeping during 'Safe Sleeping' Week in March 2022 and to consider commissioning a lunch and learn webinar by Lullaby Trust in March 2022 to embed the message
 - Signposting information about risk factors relating to SUDI on the MSCP website and in the news bulletin
 - Signposting partners to the national SUDI review and developing/sharing a 7-minute briefing
 - Policy and Training sub-group to consider commissioning training or briefings on SUDI risk factors and consider the availability of safe sleeping advice and guidance in a range of languages.