Department of Health & Social Care

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By Email to: Mailbox.NationalReviewPanel@education.gov.uk

20th May 2021

Dear Annie,

We are writing to you, on behalf of the Department of Health and Social Care (DHSC) who lead the work to prevent Sudden Unexpected Death in Infancy (SUDI). We have been working, and will continue to work, with the Home Office, and the Department for Education (DfE), who, together with DHSC, who share responsibility for Child Safeguarding.

We would like to thank Panel for their work on the Review into Sudden Unexpected Death in Infancy (SUDI). We have noted the recommendations outlined in the publication of *Out of Routine: A Review of Sudden Unexpected Death in Infancy (SUDI) in families where the children are considered at risk of significant harm,* I would like to set out to you how the Government is taking the report's recommendations into account.

We recognise the devastation to families that is caused by the sudden and unexpected death of an infant, and each death is a tragedy. Prevention and early intervention are paramount to preventing these avoidable deaths, and we want to ensure that every family receives the support and guidance they need during the early days of parenthood.

We would like to take the opportunity to set out the work the department has done in response to the SUDI report, since it was published last July:

Recommendation 1:

'We recommend that the Child Safeguarding Practice Review Panel and DfE work with DHSC, NHSE and the National Child Mortality Database to explore how data collected through Child Death Reviews (CDR) can be cross-checked against those collected through Serious Incident Notifications (SIN). The aim is to ensure consistency and rigour in both systems, and to explore how national learning from both systems can be most effectively disseminated and acted on at local and national levels.'

DHSC and NHS England and NHS Improvement have been working with the University of Bristol, who own the National Child Mortality Database (NCMD), and DfE, who hold data from (Serious Incident Notifications) SINs, to explore the possibility of improving integration between the two datasets. There are a number of legal implications that may arise from sharing data, which the teams are exploring before decisions can be made on what further action to take.

Recommendation 2:

'We recommend that, as part of its refresh of the high impact areas in the Healthy Child Programme (HCP) and the specification for health visiting, PHE 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 HCP can be expanded to involve practitioners from all agencies working with families with children at risk.'

Public Health England (PHE) are currently refreshing the *Early Years High Impact Areas* as part of the dynamic modernisation of the Healthy Child Programme. Through this refresh, PHE are considering how the learning from the Review can best be incorporated into the *High Impact Areas.* Members of the Panel have worked with PHE to help incorporate findings from the Review and have added details on SUDI into the updated guidance on the *Early Years High Impact Area 5: Improving health literacy, managing minor illnesses, and reducing accidents,* which was published on 17 March 2021.

Recommendation 3:

'We recommend that DHSC works with key stakeholders 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 wellbeing. These tools and processes are intended to supplement the current evidence-based safer sleeping advice to assist local areas in implementing effective preventive work. They could draw on the prevent and protect practice model to enable a

flexible and responsive approach, and where appropriate, incorporate relevant and validated risk assessment tools.'

Frontline health professionals – including health visitors and midwives - already have tools and processes in place to deliver guidance to families to promote safe sleeping for babies. For example, The Lullaby Trust provides a range of resources that are widely used by health visitors to deliver messages on safer sleeping. In order to provide appropriate, targeted support, specialist safeguarding midwives are alerted when a pregnant woman presents to maternity services with a history of having lost a child through SUDI. DHSC will continue to consider how these tools and processes could be extended to all frontline professionals who work with vulnerable families in order to strengthen prevention.

Research Recommendation 1:

'There is a need for practice-based research within this country to establish the efficacy of different interventions to reduce the risk of SUDI within families whose children are at risk. The literature review concludes that 'studies should use controlled observations taken from the same population and preferably as a randomised controlled trial. Where this is not possible, robust evaluations that use objective measures should be conducted.'

After reviewing this research question, DHSC have decided that it would not be feasible for the Department to undertake this research. We have concerns that this research may not be practical due to potential ethical considerations that could arise from conducting a Randomised Controlled Trial in this area.

Research Recommendation 2:

'There is a need for further research into the use of behavioural insights and models of behaviour change working with parents whose children are at risk to develop and deliver effective safer sleep messages and approaches. The use of such models should be thoroughly and carefully evaluated.'

DHSC are exploring the possibility of conducting research into the behavioural insights and models of behaviour change for vulnerable families at risk of SUDI. DHSC officials have worked with the Panel to develop a research proposal to submit to the National Institute for Health Research, who will decide whether or not to take the research forward.

Finally, we are aware that the Panel meets with our officials regularly to discuss the department's work on the recommendations, as well as wider child safeguarding matters. We would like to thank the Panel for their continued engagement with our officials to help protect vulnerable families and prevent cases of SUDI.

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MINISTER OF STATE FOR PATIENT SAFETY, SUICIDE PREVENTION AND MENTAL HEALTH