Kingston and Richmond
Safeguarding Children Partnership

Baby and Infant Safe Sleeping Practice Guidance

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Owner:	Kingston & Richmond Safeguarding Children Partnership (KRSCP)
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Name of authors:	KRSC Partnership & Louise Doherty - Designated Nurse Safeguarding Children - KINGSTON, NHS South West London CCG
Contact details:	lscb-support@kingrichlscb.org.uk louise.doherty@swlondon.nhs.uk

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1. Introduction

1.1 Kingston and Richmond Safeguarding Children Partnership partner agencies have collated this 'Baby and Infant Safe Sleeping Guidance' for the multidisciplinary workforce who have contact with parents, carers, and relatives of babies (by using the term baby we are referring to babies from birth to aged 2 years old). The purpose is to ensure practitioners have the confidence and knowledge needed to support babies' parents/carers in making informed choices regarding safer sleep arrangements and to raise awareness of the factors associated with Sudden Unexpected Deaths in Infancy (SUDI).

1.2 There is no advice which guarantees the prevention of SUDI. Safe sleep advice is shared with all new parents in pregnancy and the first few days and weeks of a baby's life by universal maternity and health visiting services. To reduce avoidable deaths, we need everyone working with families in Kingston and Richmond to help ensure safety advice and consistent, evidence-based messages are followed.

1.3 The purpose of this guidance is to:

- Provide the multi-disciplinary workforce in Kingston and Richmond with clear and consistent evidence-based information
- Provide workers with the confidence and knowledge to facilitate an open and honest discussion to support baby's parents/carers to make informed safer sleeping choices for their babies
- Ensure consistent advice about safer sleeping arrangements is given across Kingston and Richmond by all workers

2. Background

2.1 The sudden and unexpected death of a baby is one of the most devastating tragedies that could happen to any family.

2.2 In spite of substantial reductions in the incidences of sudden unexpected death in infancy (SUDI) in the 1990s, as a result of the Back to Sleep Campaign, at least 300 babies die suddenly and unexpectedly each year in England and Wales .

2.3 The unexplained infant mortality rate had been decreasing since records began in 2004 but has levelled out since 2014 and was 0.30 deaths per 1,000 live births in 2018. The

South West London 2019/2020 Child Death Overview Panel (CDOP) report stated that seven percent (7%) of deaths were classified as SUDI.

2.4 The Child Safeguarding Practice Review Panel's national thematic review of sudden unexpected death in infancy (SUDI), published in July 2020 shows that 'increasingly these deaths occur in families whose circumstances put them at risk, not just of SUDI, but of a host of other adverse outcomes'

2.5 Of the 568 serious incidents notified to the Panel between June 2018 and August 2019, 40 involved babies dying suddenly and unexpectedly, making this one of the largest groups of children notified. Co-sleeping was a feature in 38 of these 40 cases. Parental alcohol and drug use were common, as were parental mental health difficulties. Additional safeguarding concerns were also present including cumulative neglect, domestic violence, parental mental health concerns and substance misuse.

2.6 The report recognises that the contexts within which these families were living meant that understanding and acting on safer sleep messages was severely challenged for a multitude of reasons, even when those messages were 'rigorously delivered' by health professionals.

3. Responsibilities of the Multi-Disciplinary Workforce

3.1 It is the responsibility of the multi-disciplinary workforce to discuss and record, in line with record keeping guidelines of their employing organisation, the information they give to baby's parents/carers on safer sleeping arrangements at all key contacts. This refers to all professionals that come into contact with a family or anyone that has caring responsibilities for a baby.

3.2 Information must be provided in such a manner that it is understood by the baby's parent/carer. For those babies' whose parents/carers do not understand English, an approved interpreter should be used where possible and appropriate. Families with other language and communication needs, including learning disabilities, should be offered information in such a way to aid understanding.

3.3 Anyone in contact with parents/carers should take every opportunity to discuss safer sleeping arrangements for babies and highlight best practice recommendations and risks based on current evidence. This guideline should be used alongside the NHS guidance Reduce

the risk of sudden infant death syndrome (SIDS) and the Lullaby Trust's guidance How to reduce the risk of SIDS. Safer-sleep-for-babies-a-guide-for-parents-web.pdf (lullabytrust.org.uk)

4. Responsibilities of Core Health Staff

4.1 Assessment and safer sleeping discussions with parents/carers needs to start early in pregnancy and continue through the postnatal period. It is recommended that as a minimum, this information should be discussed and recorded by:

Maternity

- During the antenatal period
- As soon as possible after birth
- Prior to discharge from in-patient services
- During post-natal community visits

Health Visitor Teams

- Antenatal contact
- Primary birth visit
- Any subsequent follow up contacts

GP and Practice Nurses

- 6 week review
- Any contact with parent/carer

5. Responsibilities of other professionals

Any professional in contact with families should take every opportunity to discuss safer sleeping arrangements for babies and highlight best practice recommendations as well as risks based on current evidence.

Assessment and safer sleeping discussions with parents/carers needs to start early in pregnancy and continue through the postnatal period. It is recommended that as a minimum, this information should be discussed and recorded by:

Children's Social Care

- At any contact with a parent or carer

Children's Centres

- At any contact with a parent or carer

6. Safer Sleep Risk Assessment

The **safer sleep assessment tool** (appendix 1) has been developed to illustrate risk factors associated with SUDI. This assessment should be completed by the midwife and health visitor

during the antenatal period. This tool can support a family to better understand their own level of risk regarding safer sleeping. Following completion of the assessment, any identified needs should be addressed, with action plans set and reviewed within acceptable timescales. Practitioners should aim to see where the baby/child sleeps during the first home visit and should ask a family about any changes to sleep circumstances at every contact. Guidance and support will be offered to families at every stage.

The completed assessment form is part of the clinical record and will be shared in multi-disciplinary meetings where appropriate.

NB: Some providers in Kingston and Richmond already have safer Sleep Assessments, which are evidence based. The expectation is that the Safer Sleep Assessment within this policy should be used in the absence of any other evidence based tool.

Parents will be advised that it is not safe for babies and infants to sleep in an adult bed; adult beds are not designed with children in mind. The safest place for a baby to sleep is always in a Moses basket or cot in the same room with their parents' both day and night for at least the first six months.

PARENTS SHOULD BE ADVISED NEVER TO SLEEP ON A SOFA OR ARMCHAIR WITH THEIR BABY.

Evidence based literature consistent with the Safer Sleeping Guidance, on reducing the risk of SUDI, should be given, and discussed with all parents/carers both in the antenatal period and early postnatal period.

Each discussion must be fully recorded, alongside risk factors identified and advice given

7. Bed Sharing

7.1 *'The safest place for a baby to sleep is on their back in a cot or Moses basket, with no bumpers, pillows, blankets or toys, in the same room at their parents or carers for the first six months, day or night, at home or away".*

Falling asleep on a sofa, or in a chair, with a baby can be very hazardous and should be avoided at all times (night or day).

However, it is recognised that some parents/carers choose to co-sleep with their baby. If a parent or carer chooses to sleep NICE Guidance (2021) advocates that professionals should discuss with parent/carers' safer practices for bed sharing, including:

- making sure the baby sleeps on a clean firm, flat mattress, lying face up (rather than face down or on their side). Soft mattresses and mattress toppers should not be used
- not sleeping on a sofa or chair with the baby
- not having pillows or duvets near the baby
- not having other children or pets in the bed when sharing a bed with a baby

- Make sure that baby cannot fall out of bed or get stuck between the mattress and the wall
- Baby should not be overdressed (it is recommended that a baby only need one additional layer of clothing to what adults are wearing)

7.2 NICE guidance strongly advise parents/carers NOT to share a bed or any other surface if:

- their baby was low birth weight
- If **either** parent/carer:
  - has had 2 or more units of alcohol
  - smokes
  - has taken medicine that causes drowsiness
  - has used recreational drugs.

7.3 In Kingston and Richmond it is recommended that baby's parent/carers are advised not to bed-share or co-sleep if any of the following additional factors are present:

- If anyone sharing the room where baby is sleeping smokes (no matter where or when they smoke)
- If the parent/carer smoked during pregnancy
- If baby's parent/carers have taken medication or drugs that make them drowsy or sleep more heavily (illegal, prescription or purchased over the counter, including anaesthetics after day case or dental surgery)
- Has any illness (physical or mental) or condition that affects awareness of the baby
- If the baby has a high temperature (then medical advice should be sought)
- If the baby's parent/carer has a high temperature
- If baby's parent/carer response to their baby is impaired, for example they are excessively tired or unwell
- Parent/carers who chose to exclusively formula feed their baby should be advised that they may not naturally take up a protective sleeping position and this may increase the risk of SUDI.

NB: it is recommended that the safest place for your baby to sleep is in a cot in a room with their parent/carer for the first six months. **Please note this refers to any time the baby is asleep during the day or night.**

8. Babies who have been in Neonatal Intensive Care/Special Care

Premature babies or babies with specific health conditions are particularly vulnerable and will have specific care plans put in place when they are discharged from hospital. Premature babies often have lighter and more active sleep than babies born at full-term, and this means that they can have more frequent sleep difficulties.

A baby maybe nursed on their front/stomach (prone position) whist in a Neonatal Care Unit; this is for medical reasons and babies are closely monitored. Following discharge home

parents/carers should NOT replicate this and babies should only be left to sleep on their backs.

9. Babies who are Looked After (in foster care)

Foster carers will receive safer sleep training prior to a baby being placed in their care and are expected to agree to follow the guidance. https://www.lullabytrust.org.uk/wp-content/uploads/Safer-Sleep-Awareness-A-Guide-For-Childminders-Foster-Carers-Nannies-and-Nursery-Settings.pdf

10. Changes to Routine

It is recognised that there are times when parents/carers have changes to their normal routines which includes nights out, staying with friend/relatives or holidays. Parents/carers should be advised of the importance of having a baby sleep plan and routine, particularly if a change in sleep environment is planned, and this should include discussing safe sleeping, which includes not allowing anyone to smoke in the home or drink alcohol or be taking medication or drugs that can make them sleep more heavily. It is always better that a baby sleeps in their own cot but if using a travel cot make sure the mattress is clean, well-fitting, and firm and make sure baby sleeps on their back. Babies should not be put down to sleep in a sofa, propped in a chair or car seat.

It is recognised that changes to routine may not always be planned, and potentially in an emergency situation e.g. fleeing domestic abuse.

Appendix 1

Safe Sleep Assessment

Baby's Name **DOB** **NHS Number**

	COMMENTS		
Where did the assessment take place?			
Where does the baby sleep at night? Is this in the same room as the parents?			
Where does the baby sleep during the day? Is this in the same room as the parents?			
Are parents aware that the following environments are not recommended for safe sleep? (Sleepy head, car seat, bouncer, pram - unless flatbed pram)			
Did you see where the baby sleeps at day/night?			
	YES	**NO**	**COMMENTS**
SAFE SLEEP SPACE			
Do you share your bed with your baby?			(Include safe sleeping advice when bed sharing)
Do you ever share your bed with anyone else, including children/pets?			
Is the baby always put to bed on their back with their feet to the foot of the bed?			
What does your baby sleep in? (clothes/bedding). Is this appropriate?			
Is the family able to ensure the room temperature stays between 16-20°C?			
Do you have a plan to manage safe sleep for your baby in different circumstances (e.g. sleeping away from home, after drinking alcohol at a party/celebration)?			
RISK FACTORS			

Does anyone in your household or anyone who cares for your baby smoke			
Does anyone in your household or anyone who cares for your baby drink alcohol?			
Does anyone in your household or anyone who cares for your baby take prescribed medication or use recreational drugs?			
Does anyone in your household or anyone who cares for your baby suffer with sleep anomalies e.g. sleep apnoea?			
Does anyone in your household or anyone who cares for your baby have any mental illness which could impair mental capacity?			
Transient/temporary risk factors			
Analgesia/anaesthesia			
Compromised consciousness			
Limitation of movement/special awareness			
Unwell baby			
Support Plan: What is your support plan and what are the timescales? Completed by,,Date:,, Reviewed by:,,Date:,,			

Appendix 2:

Safer Sleeping Legislation Guidelines

If you are a person of any age and you:

- Co-sleep with a child on any surface (this includes, e.g. sofas, armchairs, beds and the floor)
- **Not under** the influence of any drug/alcohol/or substance
- Cause his/her death by suffocation

This will be deemed a tragic accident

If you are aged 16 years or over and you:

- Co-sleep with a child under the age of 3 years on any surface
- **Whilst under** the influence of drugs/substance/alcohol
- Cause his/her death by suffocation

You could be liable to criminal prosecution (Wilful Neglect) - Section 1. (2) Children and Young Persons Act 1933

If you are a person of any age and you:

- Co-sleep with a child of any age on any surface
- **Whilst under** the influence of any drug/substance/alcohol
- Cause his/her death by suffocation

You could be liable to criminal prosecution – Section 5. Offences against the Person Act 1861

Babysitters
There's no legal age to babysit, so parents should think carefully about using anyone under 16. If the babysitter is under 16, the parent remains legally responsible for the child's safety. Check that older teenagers are comfortable with the responsibility you're giving them before you leave your child with them.

Appendix 3

References

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)

Safer-sleep-for-babies-a-guide-for-parents-web.pdf (lullabytrust.org.uk)

https://www.nice.org.uk/guidance/qs37/chapter/Quality-statement-4-Infant-health-bed-sharing

https://www.lullabytrust.org.uk/wp-content/uploads/Safer-Sleep-Awareness-A-Guide-For-Childminders-Foster-Carers-Nannies-and-Nursery-Settings.pdf