SAFER SLEEPING GUIDANCE FOR CHILDREN BLACKBURN WITH DARWEN, BLACKPOOL & LANCASHIRE

This document supersedes the previous version dated April 2020 or earlier.

Document Updated: 2024

Document ratified by CDOP: 11 April 2024

Document to be reviewed: April 2026 (unless significant research or national guidelines are released in the interim)

Basis
Baby sleep info source

Child Death Overview Panel
CDOP
Blackburn with Darwen, Blackpool & Lancashire

Contents

1.0 Aims

- To reduce the numbers of babies and children who sleep in unsafe conditions by informing families of the risks of unsafe sleeping practices.
- To maximise the ability of the caregivers to implement safer sleep practices.
- To provide staff with evidence-based research to support their discussions with caregivers, in line with national guidance.
- To empower staff across agencies to identify safer sleep concerns and work with caregivers to address and mitigate risks.
- To ensure consistent advice about safer sleep is given across the multi-agency workforce in pan-Lancashire.
- To reduce the number of babies that die from sudden infant death (SIDS) across pan-Lancashire.

2.0 Scope

This guidance is applicable to the multi-agency workforce across pan-Lancashire who have contact with caregivers of babies and children and have opportunities to discuss safe sleeping arrangements. This guidance supports caregivers to make informed choices regarding safer sleep practices and raises awareness of the factors associated with SIDS.

3.0 Introduction

The Lullaby Trust tells us around 200 babies still die every year because of SIDS in the United Kingdom. (The Lullaby Trust, 2023).

Over the years, there has been a significant reduction in SIDS deaths, largely due to an increase in evidence-based knowledge and practice. The Office for National Statistics (ONS) states that the although the number of SIDS deaths have followed a general pattern of decline since records began in 2004, the rate has remained stable overall since 2014 (ONS, 2021). There were ten infant and child deaths where unsafe sleep practices were found reviewed by the Child Death Overview Panel (CDOP) in Pan-Lancashire in 2020/21 (CDOP, 2021).

This guidance has been produced and reviewed in recognition of the fact that unsafe sleeping arrangements are a feature in the majority of SIDS deaths in Pan-Lancashire. The emphasis of this document is on safer sleeping arrangements for babies, however there is also information on safer sleep for older children and safer sleep for children with special needs.

4.0 Definitions

For the purpose of this document the following definitions will apply:

Caregiver
A parent, grandparent, foster carer/s, babysitter, or any other person responsible for the baby at that particular time.

Multi-agency workforce
Any professional coming into contact with families, including the voluntary and private sector workforce.

Overlay
Overlay occurs when part of a person's body lies over the head/face of the child, therefore occluding the mouth and nose and external airways or by overlaying the chest and abdominal areas, thus preventing respiration or a combination of both. The inability to breathe leads to deprivation of oxygen and death.

Sudden Infant Death Syndrome (SIDS)
The sudden and unexplained death of a baby where no cause is found after detailed post-mortem and full death scene investigation (Lullaby Trust, 2023).

Pan-Lancashire

Pan-Lancashire is defined as Blackburn with Darwen, Blackpool & Lancashire local authority areas.

Red book
This is a child's personal health record. It is the main record of a child's health, growth, and development. It is given prior to discharge from hospital to the main caregiver following the birth of the baby. It is best practice for health professionals to document contacts and plans in this record.

Room sharing
When a baby sleeps in their carer's room in their own clear, flat, separate sleep space such as a cot or Moses basket (The Lullaby Trust, 2023).

Sofa sharing
When a parent or carer sleeps on a sofa or armchair with a baby (The Lullaby Trust, 2023).

Co-sleeping
When carers sleep on a bed, a sofa or a chair with a baby or child (The Lullaby Trust, 2023).

Sudden Unexpected Death in Infancy (SUDI)
A descriptive term used at the point of presentation of death of a baby or whose death was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to death. This term includes SIDS.

Baby
In this document, a baby refers to an infant from birth up to twelve months of age.

Child
In this document, a child refers to an individual who is over twelve months of age and up to eighteen years old.

5.0 Addressing Inequalities

All caregivers have the right to receive clear and impartial information to enable them to make fully informed choices about safe sleeping for their babies.

Staff will ensure that all care is family centred, non-judgemental and that caregivers' decisions are supported and respected. Staff will take a holistic approach, recognising the societal and psychological factors upon safe sleeping and how this may change across different demographics of caregivers.

Information and support will be fair and inclusive to and will take into account protected characteristics of caregivers. Staff will proactively ask caregivers about their communication needs. For example, caregivers who do not speak or read English may need printed information in different languages and or access to interpreting services. Caregivers with learning disabilities or sensory impairment may require access to information in different formats according to their needs.

For ease, we have used the words 'mother/s' and 'woman/end' in this guidance to denote the birthing parent, however we are aware that not everyone may use those words to describe themselves; we recognise that appropriate pronouns and other terminology should be discussed and agreed with each birthing parent on an individual basis and professionals should invite parents to tell us about words with which they feel comfortable or uncomfortable. The language used by professionals should always be inclusive.

To support inclusivity and meeting the needs of the local population, services should be responsible for ensuring that they co-design care with service users and local communities; for maternity services this can be facilitated by working closely with the Maternity Voices Partnerships, Local Maternity & Neonatal Systems and Better Births.

6.0 Safer practices for co-sleeping and bed-sharing

The safest place for a baby to sleep is always in a clear, flat, separate sleep space such as a Moses basket or cot in the same room with their caregiver, both day and night, for at least the first six months.

It is vital that professionals support caregivers to make informed choices and to ensure that these choices are made with full awareness and understanding of potential risk, as well as ways to mitigate/reduce these risks.

6.1 When to strongly advise against co-sleeping

It is important for caregivers to understand there are some circumstances in which co-sleeping with their baby can be very dangerous and is strongly discouraged. If carers have none of the above risk factors and have their baby in bed with them, there is still a small risk that their baby could die due to e.g., overheating, smothering or overlay.

- The baby was born premature or low birthweight (before 37 weeks of pregnancy or weighed under 2.5kg or 5.5lbs when they were born).
- The baby has a fever or is unwell.
- Caregiver or partner smokes, even if they do not smoke in the bedroom.
- Caregiver is extremely tired.
- Caregiver has drunk alcohol or taken drugs. This includes either prescribed or over the counter that may make them drowsy.

The safer sleep assessment tool for under one's, (see appendix 1) can be completed to help identify personal risk related behaviours, which may differ from night to night. Following completion of the safer sleep assessment, any identified risks should be addressed, and the action plan completed. If any additional needs are identified the professional should complete the Keeping Babies, Infants & Children Safe; Review of Parent/Caregiver Awareness Tool (appendix 3).

Bed-sharing may also help to facilitate breastfeeding. A study of 253 families in the North-East of England reported that mothers who started bed-sharing in their babies' first month of life were twice as likely to still be breastfeeding when their baby was 4 months of age, in comparison with women who breastfed their baby in the absence of early bed-sharing (Ball 2003). For those committed to breastfeeding, sleeping with their babies becomes one of the means by which mothers cope with frequent night-time feeding.

6.2 Reducing the risks of co-sleeping and bed-sharing

Although many new caregivers say that they will never sleep with their baby, a survey by the Lullaby Trust in 2023 found that 9 out 10 parents had co-slept with their baby (Lullaby Trust, 2023). It is important that all caregivers have a discussion with a professional/s about the risks bed-sharing/co-sleeping and consider how they will always practice safe sleep.

Baby's caregivers must be advised never to fall asleep on the sofa, chair, or bean bag with baby. If baby's caregivers choose to sleep anywhere not designed for sleeping with their baby such as the sofa, chair or on a beanbag, they must be alerted to the fact that the risk of SIDS is 50 times higher for babies when they sleep on a sofa or armchair. They must also be made aware that adult beds are not designed with infant safety in mind. Babies can die if they get trapped or wedged in the bed or if a baby's caregivers lie on them. It is the baby's caregiver's responsibility to make sure the bed environment is as safe as possible for a baby if they make the decision to sleep there.

Discussion should be had with caregivers around making sure safer sleep practices for co-sleeping are as safe as possible using the following guidance:

- The mattress needs to be clean, firm and flat. Soft mattresses and mattress toppers should not be used.
- Do not use waterbeds, electric blankets or bean bags.

- Make sure that baby cannot fall out of bed or get stuck between the mattress and the wall.
- The room must not be too hot (16 - 20° C is ideal).
- Baby should not be overdressed.
- The baby's covers must not overheat the baby or cover the baby's head. There is no need for baby to wear a hat in the house at any time.
- Pillows and adult covers/duvets must be kept away from the baby.
- The baby must not be left alone in or on the bed as even very young babies can wriggle into dangerous positions.
- Any adults in the bed must be made aware that the baby is in the bed.
- If an older child is sleeping in the bed, then an adult should sleep between the older child and the baby.
- Avoid overcrowding.
- Avoid having pets or cuddly toys in the bed.

7.0 Using a cot or Moses basket

The safest place for a baby to sleep is always in a clear, flat, separate sleep space, such as a Moses basket or cot in the same room with their caregivers, both day and night, for at least the first six months.

Having the baby sleep (day or night) in a separate room to baby's caregiver is an established risk factor for SIDS. The multi-agency workforce should advise all caregivers to keep baby in the caregiver's bedroom at night for at least the first six months, regardless of how the baby is fed.

All sleep items, such as cots and Moses baskets, should be marked with the British Safety Standard kite and the UKCA mark or the EU CE mark.

Cot or Moses basket position

- Avoid putting the cot or Moses basket next to a window, draught, fan, heater, fire, radiator, lamp or direct sunlight, as it could make the baby too cold or too hot.
- Keep the cot away from any furniture which an older baby could use to climb out of the cot.
- Keep the cot away from toiletries such as baby lotion, wipes, and nappy sacks which an older baby may be able to reach.
- Avoid curtains and blinds with cords. Dangling cords carry a risk of strangulation. Any present cords must be securely tied up and placed out of baby's reach.

Cot or Moses basket safety

- When an adult is not in the room with baby, keep the drop side of the cot up and locked into position.
- Do not use cot bumpers or padding as they are a suffocation hazard for babies. When baby starts to crawl and climb, they may also be used as steps to climb out of the cot.
- Do not use pillows, duvets, bulky bedding, or any sleep positioners such as nests and pods. This can increase the risk of overheating and accidental smothering.
- When the cot mattress is at its lowest height, the top of the rail should be above the baby's chest.
- Cuddly toys or other items should never be in the sleeping space. They could cause overheating or accidental smothering.

7.1 Buying a cot

All cots currently sold in the UK should conform to British Safety Standards BS EN 716:2017 and have a label that states:

- The cot is deep enough to be safe for the baby.
- Cot bars are less than 65mm apart.

- The cot does not have cut outs or steps.
- Should not have a side that drops all the way down.

7.2 Using a second-hand cot

Babies' caregivers must check that the cot is safe for baby. This includes:

- Points above (under 'buying a cot').
- Make sure the mattress fits snugly, there should be no corner post or decorative cut-outs in the headboard or foot board which could trap babies' limbs.
- Double check that the products have not been recalled or deemed unsafe to use.

7.3 Moses Baskets

The same sleeping advice applies as for cots, keeping the Moses basket in babies' caregivers' room for the first six months. It is recommended that a new mattress is used for each child using the Moses basket. All Moses baskets sold in the UK should conform to British Safety Standard BS EN 1466:2014 (The Lullaby Trust, 2023).

7.4 Travel cots

These should be used following manufacturers' instructions. The advice re: cots, cribs and Moses basket also applies to use of travel cots. It should be reiterated that these should not be used as a permanent arrangement or have any padding or extra blankets put underneath the baby.

7.5 Mattresses

Ideally a new mattress, which conforms to British Safety Standards (BS 7177:2008+A1:2011) (The Lullaby Trust, 2023), should be purchased for each baby. If babies' caregivers are using a 'used' mattress from a previous child, they should be advised to ensure that it is completely waterproof, has no rips, tears or holes and is still firm and not sagging. Ventilated mattresses are not recommended as they are very difficult to keep clean.

A baby should sleep on a firm, flat surface; the use of soft mattresses and toppers is not recommended. There should be no gaps between the mattress and the sides of the cot or Moses basket.

7.6 Car seats, pushchairs, and prams

Car seats or non-flat pram bases should not be used as a sleeping space in the home. A car seat is an essential item, but the following must be considered:

- Car seats are designed to keep babies safe while travelling, not as a main sleeping place. Car seats should only be used for transport and not as an alternative for cots or highchairs. Babies that get too hot are at a greater risk of SIDS. It is essential to remove any hats or outdoor clothing such as snowsuits and coats once your baby is in the car.
- Babies should not be dressed in thick or quilted clothes to keep them warm when travelling in the car. Lots of layers or heavy clothes will prevent the car seat harness from holding baby's body firmly and safely. The baby could slip out of their harness. This is a risk in the event of a crash, or on hard braking.
- It is okay for a baby to fall asleep in a car seat when travelling, but they should be taken out as soon as the destination is reached, and placed onto a firm, flat surface to sleep.
- It is recommended that babies should not be in a car seat for longer than 2 hours at a time and they should be taken out frequently – every 20 minutes as a minimum. Ideally, a second adult should travel in the back of the car with the baby, or if travelling alone use a mirror to keep an eye on the baby. If the baby changes their position and slumps forward, then the carer should immediately stop, take them out of the car seat and reposition them before continuing the journey.
- Avoid travelling in cars with pre-term and young babies for long distances.

- It is essential that the car seat is suitable for the baby's weight and is correctly fitted according to the manufacturer's instructions. Car seats must conform to safety standards - United Nations standard, ECE Regulation 44.04 (or R 44.03) or to the new a-size regulation, R129. Look for the 'E' mark label on the seat. It is recommended that caregivers do not buy or use a second-hand child seat as it may have been involved in an accident and the damage may not be visible.
- Babies' prams, travel systems and buggies should not be covered with blankets, cloths or any cover that prevents the air circulating. Covering a pram or buggy with a blanket could lead to overheating, which increases the chance of SIDS. Using a cover also creates a barrier between caregiver and baby, which increases the risk as caregivers will not be able to see if their baby is having difficulties or monitor their temperature easily.

7.7 Other baby sleep and carrying devices

There are hundreds of baby sleep products on the market and caregivers may assume that if something is for sale, it is safe to use. The Lullaby Trust has warned that some popular sleeping products for babies do not conform to safer sleep guidelines. Items such as cushioned sleeping pods, nests, baby hammocks, cot bumpers, pillows, duvets, and anything that wedges or straps a baby in place can pose a risk to babies under 12 months. Sleeping a baby on a soft surface can increase the risk of SIDS as they make it harder for babies to lose body heat and maintain a safe temperature.

It is not recommended that wedges and sleep positioners are used as evidence shows that the safest way for a baby to sleep is on a firm flat mattress, in a clear cot free of pillows, toys, bumpers and sleep positioners. Babies are at higher risk of SIDS if they have their heads covered and some items added to a cot may increase the risk of head-covering and can also increase the risk of accidents.

The Lullaby Trust gives caregivers some key pieces of advice when choosing sleeping products:

- Check whether items comply with British Standards and follow safer sleep guidelines.
- Avoid soft heavy bedding such as pillows and duvets.
- Check that anything you buy for your baby to sleep on is firm, waterproof and entirely flat with no raised or cushioned areas.

Link to The Lullaby Trust product guide - The-Lullaby-Trust-Product-Guide-Web.pdf (lullabytrust.org.uk)

There is no evidence to support the safety of sleep pods, wedges and sleep positioners.

Slings

If babies' caregivers decide they want to use slings, The Consortium of UK Sling Manufacturers and Retailers provides the following advice to baby sling wearers (RoSPA, 2019):

Keep your baby close and keep your baby safe. When you're wearing a sling or carrier, don't forget the T.I.C.K.S acronym:

Tight

In view at all times

Close enough to kiss

Keep chin off the chest

Supported back

Caregivers should ensure that they keep their baby's chin off their chest, keeping the airways clear for breathing. The safest method of baby wearing is in a carrier that keeps the newborn baby solidly against the carer's body, in an upright position.

RoSPA advises caregivers to be careful with their selection of the type of sling and to be aware that there are risks attached.

It is recommended that caregivers attend a Sling Meet near them for advice and guidance on safe use.

Caregiver must never fall asleep with their baby in a sling.

7.8 Bedding

Babies' caregivers need to ensure that the bedding in use is the right size for the cot or Moses basket, as this will prevent the baby getting tangled up.

Sheets and blankets are ideal. If the baby is too hot, a layer can be removed and if too cold a layer added. Cellular blankets should be used rather than fluffy or thick blankets.

The cot should be made up so that the blankets and sheets cover the baby up to their chest and tuck under their arms and under the mattress so that the baby lies with their feet at the end of the cot. This is a safe and recommended method as it means it is difficult for the baby to wriggle down under the bedding. Bulky bedding, adult bedding, duvets and pillows are not safe for use with babies under one year of age as they could cause overheating and/or increase the risk of suffocation.

Caregivers should be advised never to use cot bumpers; the safest cot is always a clear cot.

Specially designed sleeping bags may be used for babies who are kicking off their blankets. Babies' caregivers using these must be advised to check that the weight and size of the sleeping bag is right for baby.

Sleeping bags are designed for babies when they reach a certain weight (usually 4kg or 8.8lbs) rather than age.

For example:

- Could use 1 tog in the summer and 2.5 tog in the winter.
- The sleeping bag should fit snugly around the babies' chest so that baby cannot wriggle inside with their shoulders.
- Do not use extra blankets with sleeping bags.

8.0 Sleeping Position

The safest sleeping position for a baby is on their back, caregivers should always be advised to place baby on their back to sleep and not on their front or side.

Putting a baby to sleep on their back (known as the supine position) for every sleep, day and night, is one of the most protective actions that can be taken to ensure the baby is sleeping as safely as possible.

There is substantial evidence from around the world to show that sleeping babies on their back at the beginning of every sleep or nap (day and night) significantly reduces the risk of sudden infant death syndrome (SIDS).

Once the baby can move themselves from their back to their front and back again by themselves, they will be able to find their own sleeping position.

Wedges or props should not be used to keep baby in the same position, even though these can be used in Neonatal Units. Babies in neonatal units are under constant supervision and how a baby sleeps in hospital can be different to how they should sleep at home. Caregivers should be advised that babies with reflux should still lay flat in their cot and not be inclined as this does not help with reflux.

Caregivers will be advised the best way to make sure that their baby sleeps on their back is to do this from day one and keep putting them to sleep on their backs for every day and night-time sleep. The chance of SIDS is particularly high for babies who are sometimes put on their front and side to sleep.

There is no need to use any type of equipment or rolled up blankets to keep the baby in one position unless advised by a health professional for a specific medical condition. It is much safer for baby to be in their cot with just sheets and blankets and no extras which could be pulled over their face or cause an accident.

9.0 Twins, triplets and more

There are around 10,000 twin births and around 100-150 sets of triplets born each year across the UK. Research shows that babies who are most vulnerable to sudden infant death syndrome (SIDS) are often premature or of low birth weight, which is common in multiple births. All normal safer sleep advice applies to multiples.
Caregivers should be referred to the BASIS twin sleep information leaflet for further specific advice on safe sleeping for multiples.

10.0 Clothing

Caregivers should ensure that all sleepwear is flame retardant.

Care should be taken to ensure that suitable clothing is worn for the temperature of the room.

Babies should not wear hats for sleep during the day or night as this can increase the risk of SIDS.

Headbands and bibs should be removed before sleep.

11.0 Swaddling

There is currently inconclusive evidence about whether swaddling (firm wrapping in a cloth or blanket) is a risk factor for SIDS. Swaddling can also put babies at higher risk of bone-development problems, chest infections and overheating. It is also not considered to be a good idea to swaddle a baby when bed-sharing. Babies need to be able to use their arms and legs to alert adults who get too close, and to move covers from their faces. Swaddling prevents a bed-sharing baby from doing this.

If caregivers do decide to swaddle their baby, they should be advised to:

- Only use thin materials and no additional bedding
- Always be put to sleep on their backs and have their heads uncovered.
- Ensure that the swaddling is secure as if it is loose, it can cover baby's head and cause overheating.
- Swaddles should not be applied very tightly around the hips as this is a strongly associated with developmental dysplasia of the hip.
- Swaddling should be practiced consistently from birth, and not introduced at 2-3 months when SIDS risk is highest. Be swaddled firmly so the swaddle can’t come apart or undone but not too tightly.

Babies who can roll (e.g., from 12 weeks of age) should not have their arms in the swaddle or be left unsupervised.

A baby should never be swaddled when:

- Bed sharing.

- The baby has an infection or fever.

12.0 Dummies

The most recent UK research has found that there was no increased risk of SIDS for babies who never used a dummy, but **that if a baby was in the habit of sleeping with a dummy, then they were at increased risk when they were without it.**

This is clearly a complex issue. It is possible that when dummies are regularly used then there is an increased risk of SIDS if they are not used at the start of all sleep periods. However, the evidence base is not strong and not all experts agree.

If baby's caregivers would prefer to give their baby a dummy, it should be explained that it is advised not to give a dummy until breastfeeding is well established, usually when baby is at least one month old, and to gradually withdraw the dummy when they're between six and twelve months old.

It if a dummy is used, the following information should be advised to caregivers:

- If they choose to use a dummy, wait until breastfeeding is well established (usually around 4 weeks old).
- Stop giving a dummy to go to sleep between 6 and 12 months.
- Don't force the baby to take a dummy or put it back in if the baby spits it out.
- Don't use a neck cord.
- Don't put anything sweet on the dummy.
- Don't offer during awake time.
- Using an orthodontic dummy is best as it adapts to the baby's mouth shape.
- If you choose to use a dummy, make sure it is part of your baby's regular sleep routine.

Further information can be found on The Lullaby Trust website https://www.lullabytrust.org.uk/safer-sleep-advice/dummies-and-sids/.

Also see Safer Sleep for babies fact sheet : Dummies/pacifiers - 7-dummy-factsheet-2020.pdf (lullabytrust.org.uk).

13.0 Breastfeeding

Research has shown that breastfeeding is protective against SIDS. **The risk of SIDS is halved in babies who are breastfed for at least 2 months.** Breastfeeding for a short time can be protective for the baby. Both partial and exclusive breastfeeding have been shown to be associated with a lower SIDS rate, but exclusive breastfeeding is associated with the lowest risk.

Breastfeeding and SIDS - The Lullaby Trust
Quick access link to infant feeding guidelines
Infant Feeding - Maternity Resource Hub

14.0 Smoking and vaping

Smoking during pregnancy or after birth significantly increases the risk of SIDS and up to 30% of sudden infant deaths could have been avoided if mother did not smoke during pregnancy. This increases to 60% when including the risk of smoking in the home (The Lullaby Trust, 2024) Stopping smoking in pregnancy is beneficial for both mother and baby. It can reduce the risk of still birth, low birth weight and SIDS and mothers should be supported to quit smoking.

The evidence around vaping and e-cigarettes is still unclear, but they are less harmful than cigarettes. If using a vape or e-cigarette helps a mother to quit smoking, it is safer than continuing to smoke tobacco products.

Second-hand smoke can harm baby after birth and increase the risk of SIDS. All caregivers and individuals in the house should be aware of the risks associated with second-hand smoke for baby. Vapes and e-cigarettes do not contain carbon monoxide which is harmful to developing babies, but some chemicals are still present in the vapour at much lower levels. (NHS, 2023)

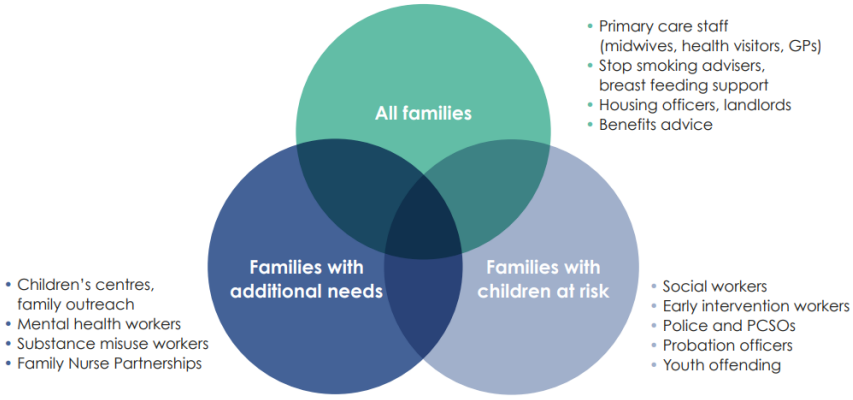
15.0 Out of Routine: Vulnerable Families

Following a review of SUDIs in children that were risk of significant harm, by the child safeguarding practice review panel, national recommendations have been made for all partners working with children and families (CSPR Review Panel, 2020).

The panel reviewed forty notifications of SUDI between June 2018 and August 2019. The review found that almost all these tragic incidents involved caregivers co-sleeping in unsafe sleep environments, often when the caregiver 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.

The major risk factors for SUDI are well known and the advice on reducing the risks is evidence-based and well established. Despite this, it was apparent from the cases notified to the Panel that this advice, for whatever reason, is not clearly received or not acted on by some of those families most at risk. It is also clear that, for this group of families, the risks to their children extend beyond the direct risks of abuse or neglect to include wider risks to their health, development, and wellbeing.

Figure 1: The SUDI continuum of risk: key professionals



The review found that where caregivers could see a clear link between the advice and an understandable mechanism of protection, it was more likely to be followed. Four key conclusions followed about how safer sleep messages should be delivered and they have incorporated them into our refreshed guidance document.

- **Caregivers need advice from someone they trust and believe** – incorporated - all trusted professionals delivering the same messages working with families.
- **Co-sleeping is both too common and too complex to apply a simple ban** – incorporated – co-sleeping should be discussed with every caregiver as part of the safer sleep assessment and caregivers advised of personal risk factors.
- **Providing caregivers with plausible mechanisms of harm, such as a risk of suffocation when co-sleeping on a sofa, could improve trust in safer sleep messages** – incorporated – the increased risk (50 times higher) of sofa sharing has been included in the 6 steps to safer sleep.
- **Planning for baby safety during disrupted routines might avoid rare but lethal scenarios** – incorporated –out of routine situations are part of the safer sleep assessment tool to be discussed at each visit from a midwife or health visitor.

16.0 Safer Sleep Advice for 2–5-year-olds

The risk of SIDS once a child reaches 12 months is greatly reduced, however sleep is important to support healthy growth, repair, and development of all children.

The sleep environment should always be a safe space and free of potential risks. Caregivers should continue to always keep children away from smoke.

Children should only move up to a toddler bed when they are old enough or they're starting to climb out of their cot which is causing a fall risk. Once a child is tall enough to climb out of a cot on its lowest level, there is a risk of injury from a fall over the top.

16.1 Bed and bedding

- Children would normally be transitioning to a bed around the age of 2 years.
- The bed or cot bed should be in good condition, appropriate for age of child, and being used for the manufactured purpose.
- Caregivers should ensure the bed/cot mattress is as low to the ground as possible.
- Generally, the height guidance for children being ready to move from a cot is 89cm and a toddler bed is much safer than going straight to an adult bed.

16.2 Bed guards

If caregivers are thinking of purchasing a bed guard, it is vital to make sure that the bed guard complies to a safety standard. The current safety standard for bed guards is BS 7972:2001 + A1 2009. The types of bed guard covered by this standard are intended for domestic use for children within the age range of 18 months to 5 years.

If the bed guard does not comply to this standard, then caregivers should be advised not to use it. The following should be advised:

- Make sure it is fitted exactly to the fitting instructions. If there are no instructions, don't use it.
- If there is any doubt about the suitability of the bed guard you're fitting, don't use it.

A bed guard used in conjunction with an adult bed is **not** considered a suitable environment for children under 18 months of age.

The principal danger from the use of bed guards is entrapment should a child's body pass through gaps and then become trapped by the head. In such circumstances, there is a real danger that the child could be strangled. There is also the risk of entrapment of a limb by the bed guard in certain circumstances.

Caregivers should be advised NOT to manufacture safety precautions to add to the bed/cot as this can increase the risk of harm/injury.

The mattress should continue to be firm, flat and in a good condition. Bedding should be appropriate for the age of the child, not too big or too heavy – risk of child becoming 'wrapped' up in adult sized quilts, which can lead to overheating or suffocation.

If caregivers choose to continue to use a cot, caregivers should ensure there is nothing in the cot that can be used as a step which could increase the risk of falling from the cot.
The child's bed should not be positioned next to a radiator, socket or window - reduce the risks of overheating or electrocution, ability to climb onto window sill and of falling or strangulation from blind cords.

The bed should be positioned where the child cannot reach wires from electrical items – risk of strangulation or electrocution.

16.3 Room

Advise caregivers that:

- Room temperature should continue to be between 16-20°.
- Windows must have a safety lock device to stop it from opening wide to reduce the risk of falling.
- Safety gates should not be fitted and used after the child has reached 24 months, and most certainly never placed on top of each other as this significantly increases the risk of entrapment.

16.4 Toys

Caregivers should ensure:

- Toys containing lithium batteries are securely fixed.
- Toys should not be stored in bed for sleeps, except for a favourite teddy (for older children).
- That IT equipment is not recommended as a strategy to settle children, visual images continue to stimulate the brain and inhibits relaxation.

16.5 Other people and pets

Children will have a more restful and hygienic sleep if in their own sleep space, not with other children, pets, or adults.

16.6 Soft toys

Evidence suggests that babies are at higher risk of SIDS if their heads become covered, it is therefore recommended that no soft toys, cot bumpers, pillows, duvets, loose bedding are in the cot, and this applies also to the period nursed in a cot on the NNU/TCU (Central Manchester University Hospitals, 2016).

17.0 Safer sleep for children with complex needs

Although children with complex health care needs must be considered when it comes to safer sleep, it is important to recognise that not one assessment can fit all.

The number of deaths in children with complex health care needs, where sleeping position has been part of, or been the main cause of death, is minimal, compared with babies. That is not to say this group of children should not have some standards of care for sleep.

Children with complex conditions all have very different and varied health care needs. We therefore recommend that the guidance should be for a health professional to review and assess the child's sleeping habits and arrangements every 4-6 months (see appendix 4). Many children with complex health care needs have sleep systems which are coordinated by Physiotherapists and Occupational Therapists, and therefore an assessment of the child's sleep requirements would include a multi-agency team approach.

It is important to note that at each visit, or contact made with the child, the nurse or health professional should always consider sleep if the child was unwell at that time and should document any conversations they have had with the family and /or other health professionals in the child's records.

18.0 Working together to reinforce safer sleep messages

Anyone 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.

18.1 Midwifery

Midwives should:

- Understand and be able to communicate the risk factors for when co-sleeping is dangerous and should be strongly discouraged.
- At the booking appointment and any follow up contacts, advise that safer sleep advice will be discussed in pregnancy and throughout the postnatal period.
- Discuss when they would feel comfortable discussing this (this may be after a dating ultrasound scan for example). The booking appointment should always, however, include signposting to relevant safer sleep guidance (for example via Badgering maternity records, push notification/recommended reading).
- Have a full discussion around safer sleep advice which should take place ideally prior to the 20-week foetal anomaly ultrasound scan but no later than the 28-week routine contact.
- Discuss safe sleep as soon as possible following birth and prior to discharge from hospital or home birth.
- Give out materials as per the timeline in appendix 5.
- Complete the safer sleep assessment tool, under one, on the maternity records (see appendix 1) following birth.
- Ask the caregivers about any changes to sleep circumstances at every contact including smoking status, changes to regular caregivers, how baby is being fed and planning for safer sleep away from the home and out of routine situations.
- Review the safer sleep assessment at the first contact following the birth and ask to see all the places where the baby sleeps, day and night, at every contact.
- Share any concerns with other professionals involved with the caregivers. Where appropriate this should be recorded in the red book.
- Complete the 'Keeping Babies, Infants & Children Safe; Review of Parental Awareness Tool' (see appendix 3), If any additional needs of any regular caregivers are identified.

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

For a communications timeline when safer sleep messages are discussed taking account of caregivers' individual needs, on a multi-agency basis, which might include Early Help Services, Primary Care, Paediatrics, Emergency Department, Social Care, or other private providers, see appendix 5.

18.2 Health Visitors

Health visitors should:

- Understand and be able to communicate the risk factors for when co-sleeping is dangerous and should be strongly discouraged.
- Discuss safe sleeping at the antenatal contact, new birth visit and all subsequent follow up contacts.
- Distribute materials as per the timeline in appendix 5.
- Complete the safe sleeping assessment - Under 1 at the antenatal visit and review at the new birth visit and 6–8-week check.
- Complete the safe sleeping assessment – Over 1, at the one-year check and review at the two-year review.
- Following completion of the safer sleep assessment, any identified needs should be addressed, with action plans set and reviewed within acceptable timescales.
- Document any concerns with safe sleeping arrangements on the safe sleeping assessments and/or in the red book.
- Ask about any changes in sleep circumstances at every contact.
- Ask to see where the baby is sleeping, for both daytime and night times sleeps, at every contact.

- Check that the caregivers have access to a cot or Moses basket and provide support for them to access one or financial aid if needed.
- Leave a copy of the safer sleep assessment in the red book so that it can be shared with any other professionals involved with the caregivers.
- Use an approved interpreter where possible, appropriate, and available when the caregivers don't understand English.
- Complete the Keeping Babies, Infants & Children Safe; Review of Parent/Carer Awareness Tool (see appendix 3,) If any additional needs are identified.

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

See appendix 5 for a communications timeline when safer sleep messages are discussed on a multi-agency basis, which might include early help services, primary care, paediatrics, emergency department or social care and other private providers.

18.3 Multi-agency workforce (including voluntary or private sector)

All multi-agency workforce staff should:

- Understand safer sleep messaging and encourage caregivers to be aware of the 'six steps to safer sleep' materials.
- Understand and be able to communicate the risk factors for when co-sleeping is dangerous and should be strongly discouraged.
- Use an 'every contact counts' approach to safer sleep messaging.
- Know where to direct caregivers for further information on safer sleep e.g., the Lancashire.gov.uk website.
- Check that caregivers have access to a cot/Moses basket and provide support for them to access financial aid if needed.
- Fill out the appropriate safe sleep assessment tool and document any discussions held in the caregiver's red book.
- Liaise with other professionals involved with the caregivers where appropriate.
- Follow any internal procedures applicable to that staff group re safe sleep.

The safer sleep assessment tool is designed to gather as much information about a baby's sleeping situation in order that appropriate advice is given and recorded in the Red Book.

It is the responsibility of the multi-agency workforce to discuss and record, in line with record keeping guidelines, the information they give to babies' caregivers on safer sleeping arrangements at all key contacts including asking to see where baby sleeps.

Information must be provided in such a manner that it is understood by the baby's carer. For babies' caregivers who do not understand English, an approved interpreter should be used where possible, appropriate, and available. Families with other language and communication needs, including learning disabilities, should be offered information in such a way to ensure understanding. If any additional needs are identified the professional should complete the Keeping Infants & Babies Safe; Review of Parent/Carer Awareness Tool (see appendix 3).

Anyone 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.

See appendix 5 for a communications timeline which outlines when safer sleep messages are discussed on a multi-agency basis, which might include Early Help Services, Primary Care, Paediatrics, Emergency Department, Social Care or private providers.

19.0 In the Immediate Postpartum Period

Mothers should have skin-to-skin contact with their new baby in an unhurried environment as soon as possible after birth as this promotes the likelihood of breastfeeding (Moore, et al., 2016). Staff should be vigilant in ensuring skin to skin contact is safe and the possibilities of any accidents are minimised. Examples of possible risk exposure include ward transfer, after operative birth, after sedative medication, and during extreme tiredness.

All mothers should be encouraged to stay close to their babies whatever their preferred baby feeding choice.
Skin to skin contact is encouraged during the postnatal period particularly, to establish the mother-baby bond, for settling babies, and for babies who are establishing breastfeeding.

In the hospital setting, separation of the mother and baby should only occur where the health of either prevents care being offered in the postnatal areas and discussed on the transfer out of hospital.
Literature consistent with this safer sleeping guidance on reducing the risk of SIDS should be given and discussed with all caregivers early in the postnatal period.

The safest place for a baby to sleep whilst in hospital is on a clear, flat mattress in a cot by the side of the mother's bed.

If a mother chooses to share their bed with their baby whilst in hospital, to maintain skin to skin contact, for cuddling or feeding their baby, staff should:

- Complete a risk assessment to consider the clinical condition of the mother (see appendix 6), other contraindications to bed-sharing, e.g., mother smokes, baby is premature or ill, the safety of the physical environment. Details of the risk assessment should be documented with the maternity record, including any risks noted and details of the advice given to the caregiver.
- Note that the mother and baby's circumstances often change quickly post birth, therefore risk assessments will need to be reviewed. Staff should ensure the following considerations are discussed and noted:

The benefits and risks (see risk factors listed on page 6) of bed-sharing are discussed to allow fully informed choice.
Written information on bed-sharing should be provided where possible (documentation must be made in the care plan/records that the information, including any risks, has been given discussed and understood). The effect of analgesia is discussed and documented in the mother's notes. The call bell must be in easy reach of the mother in the event of any restrictions to mobility or ability to care for baby.

If the mother makes a fully informed choice to bed share with their baby, all information and care given should be documented. Staff should discuss appropriate sleeping positions (in case the mother falls asleep with or without intention). The mother and baby should be monitored by staff as frequently as is practicable. Effective communication with other members of staff and on hand over of care is essential. Staff must ensure that it is highlighted that the mother is bed-sharing and what level of supervision is required. The level of supervision and frequency of checks required must be decided by a suitably qualified health professional based on an individual risk assessment.

The mother will need to take responsibility for protecting their baby from falling out of the bed/entrapment/overheating. In hospital, the bed should always be as low as possible. Direct the mother to keep the curtains or door open if taking the baby to bed so that staff can observe if they inadvertently fall asleep whilst bed-sharing.

To reduce risk, staff should direct the mother to only bed-share when another responsible adult is able to observe. Family members can be asked to support with this to ensure the baby's safety. The health professional must use professional judgement to assess the family's willingness and suitability and give basic instruction.
The presence of a family member or suitable equipment does not negate the professional responsibility and accountability for safety.

20.0 Safer sleep for babies nursed on the neonatal unit

Bliss the UK charity for babies born prematurely or sick, estimate that around 60,000 babies are born prematurely in the UK every year, averaging around 1 in every 13 babies (Bliss, 2022). Premature and small for gestational age (SGA) babies are extremely vulnerable both at birth and as they develop and are at greater risk of sudden infant death syndrome (SIDS) (The Lullaby Trust, 2023). It is therefore imperative that safer sleep guidance, safer sleep assessments and support is provided at every opportunity.

Due to the specialist care provided on Neonatal Units (NNU) and following discharge home it is felt it is necessary to discuss various areas of safer sleep guidance that may differ to a new-born baby with no complex issues being born and discharged home.

20.1 Positioning

Many babies admitted to the NNU are nursed initially in an incubator for thermoregulation and observation reasons and may be nursed prone (on their stomach) and at a 15-20 degree tilt to help with lung expansion, improved oxygenation, gastric emptying time, reflux symptoms (Parry, et al., 2023) and support neonatal development and comfort this should all be explained to caregivers and babies always remain fully monitored in the prone position.
Once babies are ready to progress to a cot (around 1.6kg) they should be nursed supine, and the cot positioned flat. Prone or side lying positions may remain clinically indicated and suggested by the Neonatal medical Team, Dietician or Speech and Language Therapists for conditions such as Pierre Robins Sequence or Cleft Lip and Palette. Communication and education with caregivers around safer sleep is imperative at this stage of progression into a cot (CLAPA, 2023).

20.2 Boundaries

Babies on the NNU may require boundaries, nests and head supports to support their tone and development and reduce complications in the future and promote comfort and reduce stress. This may be guided by unit physiotherapy and Occupational Therapy teams where available. Once a baby is assessed and their tone and development have improved boundaries, head supports, and nests should be removed. Caregiver education and guidance is imperative at this stage of progression.

20.3 Going home on oxygen

The Neonatal Consultant and team will make the decision with the family on sending a baby home on O2 support via nasal prongs. All babies (unless specifically indicated) should be nursed supine, and their set oxygen requirements will be based on saturation traces and the baby and family following discharge will be cared for in the community by the Neonatal / Children's Community Nursing Teams. All safer sleep guidance should be adhered to as normal (Parry, et al., 2023).

20.4 Safer Sleep Assessments

All safer sleep assessments should be completed by the neonatal team with the caregivers present:

- When transferring a baby from an incubator to a cot
- At the point of discharge from the NNU or Transitional Care Unit (TCU)

The neonatal outreach (NOR) team (for those babies discharged under their care) will perform a home assessment prior to the baby's discharge, to assess where the baby will be sleeping, ensure the environment is safe and no risks are present – any potential risks should be highlighted and dealt with prior to discharge home. They will also complete a safer sleep assessment on their primary community visit and on the day of discharge from the NOR team.

19.5 Car seat safety

Babies who have been nursed on the NNU/TCU on discharge may remain small and may not fit well into a car seat or may have complex issues such as continuing respiratory problems that may increase their risk of oxygen desaturations, apnoea's or bradycardias when in an upright position (Pearson, 2013).

Car seat safety is therefore extremely important and prior to discharge from the neonatal unit health professionals should assess every baby in their car seat, observe their position and perform a car seat challenge (which involves recording a baby's oxygen saturation levels for a minimum of 30 minutes). If the car seat challenge is not passed health professionals must look for alternative methods such as a lie flat car seat, this should be discussed among the health professionals and the family (Bird, 2022).

Babies should not be discharged home unless they can safely travel in a car seat.

Separate car inserts for extra support and padding unless they come with the car seat should not be used as they may not meet safety regulations.

Remove all hats and outdoor wear once in the car to avoid overheating – the back of the baby's neck or tummy can be felt to monitor baby's temperature.

Medical equipment such as oxygen cylinders can be put on the floor wedged with pillows or blankets but to check car manuals to ensure this does not interfere with airbag sensors (Bliss, 2023).

Car journeys should be kept to a minimum of 30-45 minutes for the first few months of life. If on longer car journeys, regular breaks must occur where the baby is physically removed out of the seat to allow them to stretch and move around.

If possible, a second adult should travel in the back of the car with the baby due to their small size and additional risk factors a baby's position can change such as their chin dropping to their chest or pulling out nasal prongs. If this occurs the car should be stopped immediately, and the situation dealt with.

For further advise on car seat safety for premature or sick babies, caregivers can call RoSPA Lifeline, 0808 801 0822, Monday to Friday, 9am to 4pm or email lifeline@rospa.com

19.6 Sleeping

Caregivers **should always** share a room with their baby / babies where possible but **NEVER** co-sleep with their babies (The Lullaby Trust, 2023) if they have been born premature or at a low birth weight, they should be in their own cot or Moses basket, on a firm, waterproof, flat (unless clinically indicated) mattress.

19.7 Twins and co-sleeping

Babies on the NNU / TCU may have been nursed in the same cot to improve baby's development, promote a calm and stress-free environment that mimics that of the intrauterine environment and improve and maintain thermoregulation.

However, it is imperative that the following guidance is adhered to both on the Neonatal Unit and in the home environment to promote safer sleep (The Lullaby Trust, 2024).

ALWAYS FOLLOW THE LULLABY TRUST ADVICE FOR SAFER SLEEP FOR EACH BABY FOR THEIR DAY AND NIGHT SLEEP

- Only place twins side-by-side in a cot in the early weeks, when they cannot roll over or onto each other. As soon as babies start to roll, they should go into separate cots.
- Make sure they are not close enough to touch and potentially obstruct each other's breathing or cause each other to overheat / pull out feeding tubes or nasal prongs etc.
- Babies should not be placed together in a Moses basket (or small single cot on the NNU / TCU) as they are too small for babies to co sleep safely. A Large / Paediatric cot should be used on the NNU / TCU to co-sleep and at home a large cot where the babies can have a good amount of space between them.
- The Lullaby Trust recommends for twins to sleep at opposite ends of the cot so both babies are feet to foot position with their own bedding firmly tucked in.
- Do not use boundaries or positioning aids unless medically indicated (see above).

19.8 Soft toys

Evidence suggests that babies are at higher risk of SIDS if their heads become covered, it is therefore recommended that no:

- soft toys
- cot bumpers
- pillows
- duvets
- loose bedding

are in the cot, and this applies also to the period nursed in a cot on the NNU/TCU.
The Octopus however can now be found in the incubators and cots on most NNU/TCU. The Octopus originated from Denmark where research showed that when babies hold onto the tenacles it leads to improved clinical vital signs and outcomes and less pulling and removing of tubes. All babies are monitored on the NNU and reside with the caregiver on TCU and the Octopus should be used under the guidance of health professionals and families. When the Octopus is no longer required for the above purpose, it should be removed from the cot and only used under close supervision when the baby is awake.

16.9 Dummies and benefits of non-nutritive suckling

Many babies who are nursed on the NNU AND TCU are too preterm, small, sick to take oral feeds and many babies are initially fed via feeding tubes. They may also have many procedures performed on them daily that can be stressful for them. From 11 weeks in the womb, babies practice and experience sucking which is a known soother. Non-nutritive sucking has been utilised on the majority of neonatal units for many years and is defined as any sucking when fluid is not being introduced via the mouth e.g., sucking on a dummy. Only with the informed consent of caregivers should pacifiers be utilised on the NNU/TCU (Central Manchester University Hospitals, 2016).

Non-nutritive sucking benefits include:

- Supports the development of normal feeding patterns and earlier oral feeding (to successfully oral feed babies must have co-ordinated sucking, swallowing and breathing reflexes).
- Encourages the association between sucking and having a full tummy, when offered during a tube feed and stimulates the stomach enzymes to digest milk more easily.
- Helps to soothe during tests and procedures and reduces energy expenditure, therefore improving weight gain.
- Helps improve breathing and oxygenation.
- Helps to reduce 'oral aversion' where a baby dislikes having things in their mouth.
- Can encourage the transition from tube to bottle or breastfeeding.

The dummy should only be used for the above benefits and education and guidance should be provided to caregivers once the baby no longer may require a dummy for the above reasons to follow safer sleep advice.
Caregivers can also be directed to the Lullaby Trust safer sleep guide for premature and low birth weight babies: The-Lullaby-Trust-Safer-Sleep-Advice-For-Premature-Babies.pdf (lullabytrust.org.uk)

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Safer Sleep Assessment Tool (under 1 year)

Baby's Name: DoB:
NHS No: Postcode:

	COMMENTS
Where did the assessment take place?	
Where did baby wake up?	
Where does the baby sleep at night?	
Where does the baby sleep during the day?	
Where else does the baby sleep? (Sleepy head, bouncer, car seat, pram).	
Did you see where baby sleeps day/night? (Visual assessment). If not observed, give the reason why and the planned date to see.	

	Y	N	COMMENTS
Does anyone in your household or anybody who cares for baby smoke?			
Do you ever take your baby to bed with you? Discuss safer bed sharing (in the absence of any risk factors).			
Do you share your bed with anybody else?			
Does anyone in your household or anybody who cares for baby drink alcohol?			
Does anyone in your household or anybody who cares for baby use drugs or take medication?			
Is baby always put to bed on their back with their feet to foot of cot?			
What does your baby sleep in? (clothes/bedding) Is this appropriate?			
Is the family able to ensure room temperature stays between 16-20°C?			
Have you discussed how baby is being fed?			
Do you have a plan to manage safe sleep for your baby in different circumstances or in an out of routine situation? (e.g., sleeping away from home, after drinking alcohol at a party or celebration)			

Analysis - What risk factors have been identified during this assessment?

Action Plan - What is your action plan and what are the timescales?

Completed by……..Date……

Review by……Date……..

Appendix 2 Safer Sleep Assessment Tool (1 & 2-year review)

Safer Sleep Assessment Tool (1 & 2-year review)

Baby/child's Name: Postcode:
NHS No: DOB:

	COMMENTS
Where did the assessment take place?	
Where does the baby/child sleep at night?	
Where did the baby/child wake up?	
Where does the baby/child sleep during the day?	
Where else does the baby/child sleep? Car seat, pram	
Did you see where baby/child sleeps at day/night (visual assessment)	
Bedtime routine-sleep hygiene discussed?	

	YES	NO	COMMENTS
Does anyone in your household or anybody who cares for baby/child smoke?			
Do you ever take your baby/child to bed with you?			
Does anyone in your household or anybody who cares for baby drink alcohol?			
Does anyone in your household or anybody who cares for baby use drugs or take medication that may make you drowsy?			
Have you or anyone in the household received support for drug or alcohol use?			
What does your baby/child sleep in? (clothes/bedding) Is this appropriate?			
Are you able to ensure room temperature stays between 16-20°C?			
Do you have a plan to manage safe sleep for your baby/child in different circumstances or in an out of routine situation? (e.g., sleeping away from home, after drinking alcohol at a party or celebration)?			

	Yes	NO	COMMENTS
Discussed risks re blind cords			
Loose cables/wires/sockets			
Discussion around toys with batteries/button batteries			
Is there a safety gate in place and age appropriate?			
Is the child able to climb on to window bottom?			
Are window locks in place?			
Discussed safe storage of medicines/cleaning products etc?			
Discussed water safety?			
Any other risks discussed?			

Analysis - What risk factors have been identified during this assessment?

Action Plan – What is your Action Plan and what are the timescales?

Completed by…… Date……

Review by…… Date……

Appendix 3 Keeping Babies Safe; Review of Caregiver Awareness Tool

Keeping Babies Safe; Review of Caregiver Awareness Tool

(For use by professional, when working with caregivers with additional needs)

1. **Safe Sleeping Awareness**

Advice	Aware without prompting	Awareness only when prompted	Not aware	Record verbatim caregiver's understanding of reason for this advice
Give baby a clear, flat, separate sleep space, in the same room as you, such as a cot or Moses basket. Never fall asleep with baby on a sofa or chair.				
Always protect your baby from cigarette smoke during pregnancy and after birth. If you or your partner smokes, never share a bed with your baby. This can increase the risk of death for your baby.				
Never fall asleep with baby after drinking alcohol or taking drugs, including medications that may make you drowsy.				
Always put baby to sleep on their back with feet to the foot of the cot or Moses basket, if used.				
Keep baby's head and face uncovered and make sure they don't get too hot. The room they sleep in should be between 16-20°c.				
Breastfeed your baby. If you need help with breastfeeding talk to a health professional or contact your local family hub.				

2. **What are caregivers' plans for controlling cigarette exposure?**

Mother

Father

Other caregivers or visitors to the house

3. **What plans do caregivers have for overcoming any problems they have with following the safer sleeping advice?**

4. **What will caregivers do if baby doesn't settle at night when they are implementing the safer sleeping advice?**

5. **Recognising illness**

	Response from caregiver, update using words/language	**Checklist**
How would parent/carer know if their baby was unwell?		• Off feeds • Sleepy • Persistent vomiting • Change in bowel habits • Crying more than usual • Screaming • Fewer wet nappies
What would parents/caregivers do if their baby became unwell?		• Speak to a health professional • Call 111 • Seek medical advice • Call doctor • Take to emergency department

Analysis What risk factors have been identified with this review?

Action Plan What is your action plan and what are the timescales?

Completed by:	Designation:	Date:

Appendix 4 Safer Sleep Assessment Tool (children with complex health needs)

Safer Sleep Assessment Tool (children with complex health needs)

Child/baby's Name: **Postcode:**
NHS No: **DOB:**

	COMMENTS
Where did the assessment take place? (Home ward, clinic, PAU, ED, other)	
Other assessment location details?	
Where does the baby/child sleep at night? (Advise against the use of cot bumpers, toys. blankets, sleepyhead)	
Other sleep Details?	
Where does the baby/child sleep during the day?	
Where else does the baby/child sleep? (Sleepy head, bouncer, car seat, pram)	
Did you see where baby/child sleeps at day/night? (Visual assessment). If not observed, give the reason why and the planned date to see.	
Reason why sleep area not observed?	

	YES	NO	COMMENTS
Does anyone in your household or anybody who cares for baby/child smoke?			
Please specify advice given to caregivers regarding smoking.			
Do you ever take your baby/child to bed with you?			
Does your child share a bed with anyone else/any pets? Who else do they share their bed with? Please specify advice given.			
Does anyone in your household or anybody who cares for baby drink alcohol?			
Does anyone in your household or anybody who cares for baby use drugs or take medication that may make you drowsy?			
Is baby always put to bed on their back with their feet to foot of cot?			
Have you or anyone in the household received support for drug or alcohol use?			
What does your baby/child sleep in? (clothes/bedding)			
Are you able to ensure room temperature stays between 16-20°C?			
How is the baby/child being fed? (Breast, bottle, weaned, combination, nasogastric (NG), orogastric (OG), percutaneous endoscopic gastrostomy (PEG)).			
Do you have a plan to manage safe sleep for your baby/child in different circumstances or in an out of routine situation? (e.g., sleeping away from home, after drinking alcohol at a party or celebration)?			

Analysis - What risk factors have been identified during this assessment? Have you contacted the Health Visitor using the Paediatric Liaison Form?

Action Plan – What is your Action Plan and what are the timescales?

Completed by…… Date……

Review by…… Date……

Appendix 5 Safer Sleep Opportunity & Distribution Timeline 2024

See separate attachment.

Appendix 6 Clinical condition of the mother (postpartum)

Clinical condition of the mother (postpartum)

Any mother who may be unable to remain awake or sustain consciousness or who may have restricted movement or severe difficulty with spatial awareness will require supervision when sharing a bed with her baby. It is not advisable for mothers to bed share unless constantly supervised.

Examples of would include mothers who are:

- Under the effects of a general anaesthetic.
- Immobile due to spinal anaesthetic.
- Under the influence of drugs which cause drowsiness.
- Ill to the point that this may affect consciousness or ability to respond normally e.g., high temperature, following large blood loss, severe hypertension.
- Excessively tired to the point that would affect ability to respond to the baby.
- Suffering any condition that would affect spatial awareness e.g., Conditions that would severely affect mobility and sensory awareness such as multiple sclerosis or paralysis, or conditions affecting spatial awareness such as blindness.
- Very obese (individual assessment will be required, preferably with the mother, based on the mother's mobility, spatial awareness, and the space available in the bed).
- Likely to have temporary losses of consciousness e.g., Insulin-dependent diabetic, epileptic.

The level of supervision required will depend on the severity of the mother's condition. This will need to be assessed by a suitably trained health professional. When possible, this assessment should be carried out in consultation with the mother. It is not advisable for mothers to sleep with their baby unless constantly supervised.

Appendix 7 Safer Sleeping Legislation Guidelines

Safer Sleeping Legislation Guidelines

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

- You are aged 16 years or over.
- Co-sleep with a child under the age of 3 years old.
- On any sleeping surface e.g., a bed or any kind of furniture or surface used for the purpose of sleeping.
- Whilst under the influence of drink or a prohibited drug
- Cause his/her death by suffocation.

This offence is often referred to as 'Criminal Overlay'.

Lancashire Constabulary
police and communities together

CDOP

Timeline Key:

- Blackpool only - Red
- Blackburn with Darwen only - Green
- Pan-Lancashire - Blue

Yellow box - hard copy materials should be given at the appointment. Contact your local CDOP.

Safer Sleep Opportunity & Distribution Timeline 2024

Up to 12 weeks – booking in appointments.	Safer Sleep can be discussed at this appointment if required (optional). Signpost to e-booklet.
25-34 weeks - Bump, Birth & Beyond/Baby Steps (in Blackpool) offered at Neighbourhood Centres.	Advice provided to expectant care givers. Available for all, however, the take up is not universal.
Premature Births/ babies on NICU/ or Vulnerable babies (CONI Scheme).	Midwife/neonatal nurse delivers messages to carers. and has tailored conversation, complete safer sleep assessment tool. Booklet provided.
28 weeks plus – antenatal visit by the Heath Visitor.	1 hour session with the health visitor where messages are explained in depth, booklet and thermometer provided. Ask to check where baby sleeps. Complete safer sleep assessment tool.
36 weeks - Birth Talk.	Safer Sleep can be discussed at this appointment if required (optional). Signpost to e-booklet.
Birth (40 weeks approx.).	Safer sleep messages reinforced at birth and at midwife examination. Cot card & thermometer distributed. Complete safer sleep assessment tool.
Early Infancy Visit - 1st home visit post birth (midwife).	Complete safer sleep assessment tool. Reiteration of safer sleep messages and risk factors, ask to see where baby sleeps. Signpost to e-booklet.
Transfer of care visit (Midwifery to Health Visiting).	Complete safer sleep assessment tool. Reiteration of Safer Sleep messages and risk factors, ask to see where baby sleeps. Signpost to e-booklet.
0-14 days post birth - New Birth Visit (health visitor).	Offer thermometer and booklet to care givers (if not received). Health Visitor should ask to see where the baby sleeps. Complete safer sleep assessment tool.
Early Infancy Visit - Up to 8 weeks home visit (health visitor).	Reiteration of safer sleep messages and risk factors, ask to see where baby sleeps. Signpost to e-booklet Complete safer sleep assessment tool.
6-8 weeks post birth - Mood assessment/HV check.	Complete safer sleep assessment tool. Ask to see where baby slept last night/discuss any changes to sleep arrangements/patterns.
3–4-month visit (Health Visitor).	Complete safer sleep assessment tool. Reiteration of safer sleep messages and risk factors, ask to see where baby sleeps. Signpost to e-booklet.
3-4 months post-birth – mood assessment (targeted).	Complete safer sleep assessment tool BwD reinforce messages at home if CAF is in place (targeted families only).
8, 12 & 16 weeks – Immunisations.	Posters displayed in GP surgeries. Safer Sleep message reinforced at 8, 12 & 16 week immunisations.
8-12 months development check – Clinic/visit.	Safer sleep messages reinforced. Complete safer sleep assessment tool.
2-2.5-year review.	Safer sleep should be discussed at this appointment. Refer to the pan-Lancashire guidance and complete the safer sleep assessment tool.
3-3.5-year review.	Safer sleep should be discussed at this appointment. Refer to the pan-Lancashire guidance and complete the safer sleep assessment tool.

20 weeks plus – pre-birth assessment (if applicable). Children's Social Care to signpost care givers to the e-leaflet and reinforce the messages during the pre-birth Assessment.

Posters displayed in family hubs, CSC family centres, surgeries, pharmacies, libraries, maternity wards, A&E, walk-in centres, breastfeeding groups and Children Family & Wellbeing Service settings.

Key message PowerPoint available for team briefings, full toolkit available on the CSAP website.

V1.0 FINAL – 25/04/2024 - Timeline correct at time of publication and is subject to change. This timeline will be reviewed annually.