CO-SLEEPING THEMATIC REVIEW

SOUTHAMPTON LOCAL SAFEGUARDING CHILDREN BOARD

Graham Bartlett, Independent Reviewer

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1. Introduction

1.1 In June 2018, Southampton Local Safeguarding Children Board commissioned a thematic review into co-sleeping due to an increased number of deaths of babies as a result of co-sleeping and overlaying in the city. Since 2016 the Child Death Overview Panel (CDOP) had four referrals of deaths of children related to co-sleeping. Two of these met the criteria for a Serious Case Review (SCR)[1]. The timing of the review was such that it could not report until the second of these SCRs had concluded.

2. Terms of Reference

2.1 This will be a thematic review and analysis of common issues regarding co-sleeping across the two cases of 'Reece' and 'Billy' plus any identified CDOP cases with modifiable factors. The review will be presented as an addendum report to Reece and Billy SCR review reports.

2.2 The review will reference Reece and Billy SCR reports and consider CDOP cases where cosleeping was a factor from 1st April 2016 to 1st April 2018.

2.3 This review will request relevant background and contextual information regarding key factors and significant events about the families that was known or knowable by the agency at the start of the review period.

2.4 This will include any relevant agency knowledge outside of the period of review. To include the time prior to the review period regarding the family background and any other important and relevant information.

2.5 The SCR Group will act as the reference panel for this review and the lead reviewer is Graham Bartlett, Independent Reviewer.

2.6 This review will consider all issues that could have a bearing on the circumstances of this case and will include:

- National learning
- Best practice
- Timing of health professionals providing safe sleep messages and when these are reinforced (and by whom)
- Assessment of home environment in respect of safe sleeping

2.7 The lead reviewer will consider from summary information provided the involvement of relevant staff in this case to ensure any possible learning opportunities are identified and acted upon.

2.8 The lead reviewer will notify the family members of the review and they will be invited to participate as and when appropriate.

2.9 The methodology for this review will consist of:

- A review of co sleeping as a theme using the case of Reece, Billy and Southampton CDOP cases with modifiable factors from April 2016 - April 2018.
- A review of relevant multi agency policies, procedures and processes that are in place
- Facilitation of multi-agency learning event, to explore with partner agencies the blockages and barriers that have hindered implementation of the learning.

[1] Reece and Billy Serious Case Reviews

- Partner organisations will then have an opportunity to agree actions to address blockages and barriers identified.
- Focused learning and suggested improvements and outcomes with regard to co-sleeping issues in Southampton.
- This will be chaired by an independent reviewer who will produce an addendum report outlining key findings and multi-agency recommendations.
- The Lead Reviewer will request details and further information where necessary to support analysis and scope of the review. This may involve minutes of meetings, written assessments made and other relevant information.
- In depth analysis of sub themes and any gaps identified

3. Lead Reviewer

3.1 Mr Graham Bartlett was appointed as lead reviewer and author for this review. He is the Director of South Downs Leadership and Management Services Ltd and Independently Chairs the East Sussex and Brighton and Hove Safeguarding Adults Boards. Until recently he was the Independent Chair of Brighton and Hove Local Safeguarding Children Board. He has undertaken the Social Care Institute for Excellence Learning Together Foundation Course. He is an experienced lead reviewer and author of Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.

3.2 He is a retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for the city of Brighton and Hove. He had previously been the Detective Superintendent for Public Protection which entailed being the senior officer responsible for the Force's approach to Child Protection, Domestic Abuse, Multi Agency Public Protection Arrangements (MAPPA), Missing Persons, Hate Crime, Vulnerable Adults and Sexual Offences. He retired in March 2013. He had no involvement or responsibility for any policing in Hampshire or Southampton.

3.3 He was the lead reviewer for both the Reece and 'Billy' Serious Case Reviews.

4. National Picture

4.1 In 2011, The Foundation for the Study of Infant Deaths (now The Lullaby Trust) published a ten year study into the correlation between co-sleeping and Sudden Infant Death Syndrome (SUDI/ SIDS)[2]. The study concluded that almost two thirds (59%) of unexplained SUDIs involved co-sleeping compared to 44% of explained SUDIs and co-sleeping is associated with unexplained SUDI/SIDS in infants aged under six months, suggesting that co-sleeping is related to the pathogenesis of death in younger infants.

4.2 A study published in the British Medical Journal in 2013[3] found that bed-sharing when the parents do not smoke or take alcohol or drugs increases the risk of SIDS. Those risks, associated with bed-sharing, are greatly increased when combined with parental smoking, maternal alcohol consumption and/or drug use. It concluded that a substantial reduction of SIDS rates could be achieved if parents avoided bed-sharing. This study is cited on the NHS website along with accessible guidance to reduce the risks through co-sleeping.[4]

[2] https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1440-1754.2011.02228.x
[3] https://bmjopen.bmj.com/content/3/5/e002299
[4] https://www.nhs.uk/news/pregnancy-and-child/sharing-a-bed-with-your-baby-ups-risk-of-cot-death/

4.3 The Office of National Statistics data of 2016[5] (the latest year available) indicate there were 219 unexplained infant deaths in England and Wales that year, an increase compared with 2015 (195), but still lower than in 2006 (285). In 2016, the unexplained infant mortality rate rose to 0.31 deaths per 1,000 live births, however, the rate was not significantly higher than the 2015 rate (0.28) but was significantly lower than in 2006 (0.43).

4.4 Unexplained infant deaths accounted for 8.3% of all infant deaths in 2016, compared with 7.6% in 2015. In 2016, the unexplained infant mortality rate remained the highest among mothers aged less than 20 years, at 0.98 deaths per 1,000 live births, an increase from 0.79 in 2015. In 2016, the unexplained infant mortality rate among very low birthweight (under 1,500 grams) babies increased to 2.13 deaths per 1,000 live births, compared with 1.24 in 2015.

4.5 A Freedom of Information request made to the Department for Education by The Mirror Newspaper Group[6] suggested that the numbers of deaths associated with co-sleeping was rising with 141 in 2017, 131 in 2016, 121 in 2015, 141 in 2014 and 131 in 2013.

4.6 The Lullaby Trust publishes a range of information and guidance, including a bed sharing fact sheet,[7] to help parents reduce the risk of Sudden Infant Death and for professionals to support them in doing so[8],. One of the key messages within the fact sheet is *'Never sleep on a sofa or in an armchair with your baby. This is one of the most high risk sleep situations for your baby.'*

4.7 Some professionals suggest that marketing and advertising can sometimes, inadvertently, provide misleading guidance and imagery regarding co-sleeping, making it appear a safe and healthy option.

5. The Local Picture

5.1 During the period under review there were four deaths associated with co-sleeping in Southampton.

5.2 The most recent CDOP Annual Report (2017/18)[9] reports that there were five deaths reviewed for the Southampton Area. Clearly that is too small a number to draw any statistical conclusions but, across the 4LSCB area[10], 3% (2) were recorded as Sudden Infant Death. This is a decrease from 2016/17 which saw twenty two deaths reviewed for the Southampton Area with fewer than five recorded as Sudden Infant Death.

5.3 The 2016/17 CDOP[11] report did not highlight any particular trends around co-sleeping but the following year the report noted that the 4CDOP area had seen several deaths related to sleeping practices. In most cases it has occurred along-side co-sleeping in bed with risk factors such as smoking, alcohol or drug use or sometimes sleeping on a sofa.

5.4 CDOP recommended promoting safe sleeping messages and supporting the Lullaby Trust annual awareness campaign. It also asked that health agencies, through the health subgroups of the respective LSCBs, ensure that all staff are fully aware of

5 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/unexplaineddeathsininfancyenglandandwales/2016

6 https://www.mirror.co.uk/news/uk-news/133-babies-accidentally-dying-every-11929780

7 https://www.lullabytrust.org.uk/wp-content/uploads/4-bed-sharing-factsheet-2018.pdf

8 https://www.lullabytrust.org.uk/safer-sleep-advice/

9 http://southamptonlscb.co.uk/wp-content/uploads/2019/01/4LSCB-CDOP-Annual-Report-2017-18.pdf

10 Hampshire, Southampton, Portsmouth, Isle of Wight

11 http://southamptonlscb.co.uk/wp-content/uploads/2017/11/CDOPAR2016-17-Final.pdf

current policies and guidance and routinely communicate the risks of unsafe sleeping effectively with parents and families.

6. Local Provision

6.1 Solent Health NHS Trust provide the Health Visiting and Community Health Nursing services for Southampton. They report having recently developed a Safer Sleep Guideline, to provide consistency across the Trust. They have also facilitated Safer Sleep workshops to almost all health visitors and community health nurses in Southampton and are widening this to local Southampton City Council and wider Children & Family teams as they get capacity to do so. They use a range of resources from the Lullaby Trust, including the safe sleep advice referenced above. They also signpost parents to a video on the Wessex Healthier Together website which advises on reducing the risk of SIDS[12].

6.2 It is now the policy that safe sleep is discussed and recorded at each antenatal contact, new birth visits and 6-8 week review by a health visitor or community health nurse. Also, at any ad hoc or as required contact. As well as giving information regarding safer sleep, they are adopting an enquiry/curious approach with parents eliciting a more meaningful conversation. There appears to be no guidance around checking sleeping arrangements nor any about differentiating advice and support for those families who present with higher SIDS risk factors.

6.3 University Hospitals Southampton NHS Foundation Trust provide acute hospital services to the city. They report that midwives are expected to discuss safe sleeping with all parents. They have a laminated crib sheet which includes a section on baby safety and directs them to advise parents on how a baby should be positioned when lying down and that a cot should be used.

6.4 Midwifery now triage bookings which enables them to identify vulnerable families who are then provided enhanced support leading to the Echo health visiting programme as appropriate and if the mother so wishes.

6.5 They do not provide any handouts on safe sleeping, instead parents are given a discharge pack. On the envelope of the pack is a QR code that links to support and information including safe sleeping. It would be an expectation that parents are shown the QR code.

6.6 Safe sleeping advice is in the Child Health Record (red book) and this should be given out by the health visitor at the antenatal visit. However, this is not always achieved and is, at times, given out postnatally by the health visitor at the new birth visit. Therefore, it is rarely possible to use it as an aid when discussing safe sleeping with families on discharge from hospital, as parents do not always have one at that stage.

6.7 The Neo Natal Unit (NNU) advise that as part of their admission to discharge checklist there is a section to be documented that a safe-sleep discussion has taken place and an information leaflet given. There is no current guidance and patient information leaflets on safe sleep available on the children's wards.

6.8 There appears to be no guidance around asking about sleeping arrangements nor any about differentiating advice and support for those families who present with higher SIDS risk factors.

6.9 The named GP for children's safeguarding reports that GPs are unlikely to routinely discuss the topic of safe sleeping as it is usually covered by Midwives and Health Visitors. This GP reports carrying out the six week and postnatal checks in her own practice and by that point there are often entries in the mother's and child's records from

[12] https://what0-18.nhs.uk/solent/health-visiting

the Health Visitors mentioning that safe sleeping and SIDS have been discussed. Depending on the confidence she has in the parents, she might ask where the baby sleeps, particularly overnight, but she does not do this routinely. She is not aware of any local policies in primary care and GPs have not received any training or regular updates in the area.

6.10 Children's Social Care do not currently have a specific policy in respect of co-sleeping. They report working with the health visitors about this advice on a needs basis. Depending on the family and the areas of concern this would be recorded in minutes of meetings e.g. Child Protection Conferences, Core Group Meetings or Child in Need meetings. On occasions this advice may be incorporated into a working agreement or contract of expectations with the family. Where there are issues, around drugs or alcohol for example, then the health advice would be reinforced by the social worker.

6.11 Southampton City Council Family Engagement Workers have developed and delivered a Safe Sleep Workshop which is aimed at both parents and professionals. Whilst it covers many aspects of sleep related issues, including those experienced in older children and teenagers, it does provide accessible and essential information regarding Sudden Infant Death Syndrome.

7. Summary of Co-Sleeping Deaths[13]

REECE

7.1 Reece was a non mobile baby under 3 months old when he died. He had been born at 41 weeks' gestation at 7.3lbs. His mother was seventeen years of age and he had a toddler aged brother. His mother had unstable housing arrangements and, a few days before Reece died, they were re-housed to a one room supported accommodation flat with his mother's partner staying a few nights per week.

7.2 South Central Ambulance Service were called as Reece had reportedly been found unresponsive in his Moses basket. He was in cardiac arrest and the family were performing CPR. When the ambulance arrived, the paramedics found that he was stiff. He and his mother were taken to the Southampton General Hospital where, following unsuccessful CPR, he was pronounced dead.

7.3 His mother told police that he had been placed to sleep in his Moses basket after a feed at about 01:30 and found shortly after 06:00. However, information from her partner, comments from the younger sibling and evidence found in a search of the home address, led police to suspect that he may have been sharing his mother's and her partner's double air mattress on the floor.

7.4 His mother told police that she and the two boys lived in the single room and that her partner stayed two or three nights a week. She said the adults slept on the airbed, the three year old had a toddler bed in the room and Reece had a Moses basket, also in the room. She said Reece had been formula fed since birth and would routinely take 6oz every two to three hours on demand.

7.5 His mother said she smoked about three to four roll-ups a day throughout her pregnancy and had smoked five to eight roll-ups a day since Reece was born. She said she did not smoke in the house but kept an ashtray inside.

7.6 Both his mother and her partner admitted occasionally smoking cannabis but not in the house nor in front of the children. A small amount of herbal cannabis was found

[13] All names are pseudonyms

in the house which, she said, she found down the side of the sofa and did not know to whom it belonged.

7.7 Reece had been well all day and had fed normally. He usually woke two or three times in the night for a feed but, on the night he died, he did so only once.

7.8 When she found Reece, his lips were blue, he was stiff and unresponsive. She picked him up and his head flopped. She took his vest and baby-grow off in an effort to wake him up but could not. She shook him a little but still could not wake him.

7.9 Police noted a large wet area in the middle of the airbed at the head end. One pillow was wet and had traces of vomit on it. The duvet also had a wet patch and traces of vomit. There was a baby-grow and vest at the foot of the Moses basket adjacent to where the foot of the air bed would have been. These were also wet and had what appeared to be vomit on them.

7.10 The Moses basket had a clean fitted sheet on the bottom underneath which was a towel. Inside the basket was a toy, a remote control, a muslin and fleece blanket. There did not appear to be any wet or vomit on these items, the sheets or the sides of the Moses basket.

7.11 The mother's partner said that Reece had been asleep between him and his mother and that this was not unusual. He told officers they might have overlaid him. He added that Reece had a history of being sick after his feeds and would sometimes poke his tongue out and gag when laid down.

7.12 The following week a post mortem examination was performed but the cause of death could not be ascertained. Given that investigations in the following months could not provide any more clarity, at the inquest, an open verdict was recorded.

7.13 Reece, his mother, brother and extended family were well known to agencies for a range of health and welfare concerns. Her first child was born when she was 14, and Reece when she was 17. She had miscarried in between. Reece's brother had been subject to a Child Protection Plan twice, each time then being stepped down to a Child in Need (CiN) plan.

7.14 Reece was made subject to Child Protection Planning under category of emotional abuse prior to his birth but stepped down to a Child in Need plan before he was born.

7.15 The family had been rehoused just days before Reece died. His mother felt the accommodation was totally unsuitable for the size of her family and as a safe place to bring up children. She said it was very cramped – the airbed had to be moved to the bathroom during the day – and everyone slept in the same room.

7.16 Despite their needs and housing history, no one actually visited and viewed that accommodation from a safeguarding perspective prior to them moving in. There was no assessment view as to its suitability to meet the family's needs. No Children and Families Services visit was made between them moving in and Reece's tragic death. A Health Visitor visit was attempted but was unsuccessful as the mother had gone out.

7.17 The mother's demographic (which is fully discussed in Reece Serious Case Review), and the possibility of her and her partner smoking tobacco and cannabis near Reece, put Reece in a higher risk group for SIDS. There is nothing to suggest that his mother received anything other than generic advice to reduce this risk, although she does not remember receiving any such advice.

CHILD A

7.18 Child A was 6 weeks old when he died in September 2017. He was induced to birth one week early due to concerns over his mother suffering pre-eclampsia. He

attended the NNU unit for a few hours due to initial low blood sugar levels but this stabilised and he left hospital after only a few days. He had no other medical concerns and whilst low in weight (5.3lb) had only been to the GP once over concerns for a cold but was well before he died. The pregnancy had been unplanned and the mother and father were no longer in a relationship when Child A was born, although they had previously been in a long term relationship.

7.19 Child A's mother was 19 years old when he died. She had a history of emotional difficulties but not for at least a year prior to Child A's birth. She had a previous pregnancy with the same father but this did not go to term. She lived with her mother and siblings and received good support. The house was described as clean but clutter reduced the space.

7.20 Child A's mother was unwell the day before he died and she cared for him in the afternoon. He sometimes slept in his crib but most of the time he slept in his Sleepyhead[14] in his mother's bed. When he and his mother returned home about 16:30, Child A went to his grandmother. She put him into his pram and fed him at 17:30. His mother fed him next about 19:30. At either 21:30 or 22:30pm he was fed by his mother upstairs and went into his Sleepyhead in his cot. After the next feed at half past midnight, he went back into the Sleepyhead, this time in his mother's bed.

7.21 The next feed his mother remembers was at 03:30 when she propped him up on a pillow in her bed to feed him. She fell asleep and found him at about 08:00, face down on the mattress (which had no sheet on it) just below her pillows. He had dry blood on his cheek and around his mouth. Resuscitation was attempted but was not successful.

7.22 Child A was wearing a vest and sleepsuit and a disposable nappy. There was a quilt and cover on the bed but his mother could not remember if she had it on her. It definitely was not on the baby, she said.

7.23 Professionals saw a bottle on the bed against the bottom of a pillow with a small amount of milk in it. His mother remembered the bottle possibly being between the baby and her. The post mortem showed the cause of death to be unascertained.

7.24 There was no suggestion of Child A's mother smoking, either ante or postnatally, of her using alcohol or drugs or of any abuse or neglect being a factor in the household, including domestic violence. She had disengaged from the Family Nurse Partnership (FNP) before Child A was born but engaged well with the universal health visiting service and other clinical services. Records show that FNP provided safe sleep advice but other services do not report this.

7.25 Child A's mother told the review that her involvement with the health visitor was brief, with only two visits. She recalled discussing safe sleep and her impression was that the health visitor underplayed the risks saying that her 'mother's instinct would alert her to any problems the baby might have in his sleep.' She recalled receiving information on discharge from hospital but recalls this as being part of a generic discharge.

7.26 Child A's mother told the review that she was disappointed by the lack of aftercare services for parents whose children died in infancy. She had no support other than from a suicide bereavement service who chose to fill the void when they heard about her case. Whilst outside the scope of the review, the LSCB may wish to enquire further into this as it seems a worrying gap in provision for those who have suffered one of the worst losses imaginable.

7.27 There were no existing or underlying factors, other than co-sleeping that the Child Death Overview Panel found as contributory to this tragic death.

[14] https://sleepyheadofsweden.com/

CHILD B

7.28 Child B was six months old when he died at home in December 2017. He lived with his father, his mother and his half brother and sister.

7.29 He had been born at 30 weeks and 2 days at 3.7lbs. He remained in NNU for several weeks and was discharged with no concerns and for routine follow up. His mother was at NNU most of the time and his father visited after work and at weekends. On discharge he received a routine universal service from health visiting team but with a history of poor engagement at times He received his first and second immunisations but there is no record to indicate he received the third, due in October 2017.

7.30 Over the three or four weeks prior to his death, Child B had been experiencing breathing difficulties, his breathing being fast and loud. His mother took him to the GP who diagnosed a cold. A few days later, she took him back again as Child B's chest was worse. He was given a five day course of antibiotics.

7.31 He remained 'chesty,' according to his mother, and four days before he died she took him to A+E where he was diagnosed with bronchiolitis. As it was viral he was not given any medication but his mother was advised to give him Calpol and that it could take six weeks for him to recover.

7.32 The nurse visited them the following day. She reported that he appeared to be 'OK'. Child B had taken his bottles of milk but had been sick on numerous occassions. His mother spoke to the nurse the day before he died who advised they feed him one or two ounces at a time which she did and he managed to keep that down.

7.33 On the day of his death, Child B seemed to be getting better. He was trying to talk, was babbling, laughing and smiling. The parents put a double size foam matress on the floor in the living room so they could watch TV and keep an eye on him.

7.34 They got ready for bed and around 22:00 gave Child B his last bottle which he kept down. His mother went to sleep on one side of the mattress, Child B was in the middle and his father on the other side. Child B was at the top of the matress with his head on a pillow and was nearer to his mother than his father. His father fell asleep between 23.00 and 23:30pm.

7.35 His father awoke in the night to go to the toilet, looked across and could see Charlie on his back, in the same position as earlier in the night but noticed he did not look 'right.' He woke his partner up then called the ambulance. Child B's mother attempted CPR until the ambulance arrived. She went in the ambulance while his father stayed home to look after the other children. Child B was dead on arrival at the hospital. Police observed advanced rigor mortis suggesting he had been dead for some time before he was discovered.

7.36 The parents provided urine samples which confirmed they had no alcohol or controlled drugs in their systems. This corroborated their account of not having drunk alcohol that night. There was no smell of smoking in the house but there were unused cigarettes around.

7.37 The parents said they do not usually sleep in the living room but had the last two nights as it was warmer, given the draught in the bedroom. The mattress did not appear to be a standard mattress but a piece of foam approximately the size and depth of a double mattress. A mattress of this type would not comply with health recommendations in relation to safe sleeping for a baby under a year old. The mattress would offer limited circulation of air and an inadequate firm surface for a young baby[15].

[15] https://www.lullabytrust.org.uk/safer-sleep-advice/mattresses-and-bedding/

7.38 It had a clean fitted bottom sheet and the parents reported they propped Child B up with a pillow just above his shoulders with an average weight duvet as a cover. They report that, when they attended the hospital four days before his death, they were advised to prop him up in this fashion. There is no record of this advice within the hospital who reported this would not be recommended advice.

7.39 Both parents are smokers and the father was previously a drug user. The mother was previously under the care of mental health services and had been on medication for depression. The step children had previously been on Child Protection Plans but none of the family were then open to social care.

7.40 Health visitor records indicate that the parents had been informed about the risks associated with co sleeping and the health recommendations in relation to reducing the risk of sudden infant death. The home visit conducted after Child B died indicated there were some clear risks in sleeping arrangements. It is not known to what level the parents understood these risks, especially considering anxieties of having a recently unwell child and wanting to keep close contact with him.

7.41 Unfortunately Child B's parents did not respond to the request to speak with the lead reviewer and, given their bereavement, this was not pursued further as it was felt important to respect their privacy.

BILLY

7.42 Billy was 4 ¾ months old when he died, having been born prematurely at 28 + 5 weeks weighing 3lbs, in 'poor condition' with respiratory distress syndrome, feeding problems – prematurity, prolonged rupture of membranes with associated infection and moderate pulmonary artery stenosis. He spent his first forty five days in hospital then a further 3 ½ weeks with bronchiolitis.

7.43 The family had a long history of child neglect, emotional abuse and unexplained injuries. Billy's mother was eighteen when she had her first child and twenty-five when she had Billy, the youngest of six children. As well as the six children, she had a miscarriage during these seven years. The four older siblings had been on Child Protection Plans in 2014/15 but stepped down to universal services within the year.

7.44 His mother was a smoker who continued to smoke during pregnancies and beyond. There were concerns over parental attachment, supervision and capacity. There were suspicions of non-engagement and the children not being brought to clinical appointments.

7.45 In February 2018, Billy's father woke just after 07.30 and went to see Billy who was sleeping on a sofa in the lounge of their three bedroom flat with his mother. At first Billy's father could not see him. He then pulled back a blanket and saw that Billy was face down under it. He had rolled into the frame of the sofa in the gap between the cushion and the back. On picking Billy up, he saw he was a blue/ purple colour. He had no further injuries but never regained consciousness. It appeared that his mother had overlaid Billy whilst sleeping, pushing him into the sofa frame.

7.46 Following Billy's latest discharge from hospital, his mother told police he was no longer able to sleep in the Moses basket and would scream through the night. As a result, she said she would sleep with Billy on the sofa to allow them all a normal sleep. She said she had never previously slept with a child in her bed and that Billy was the first.

7.47 The sofa was a L-shaped corner style sofa. The wooden frame was only covered by a thin layer of material which his mother would cover with a duvet in the area where Billy would sleep. She would lay under the duvet on the outside edge of the sofa facing in. She would then have a pillow which she would cover with a blue blanket. Billy

would then sleep on this, between her and the back of the sofa. It was from here that he appeared to have rolled into the frame.

7.48 This was a family that were very much at high risk of SIDS, with Billy being preterm, low birthweight, exposed to maternal smoking. His mother had little antenatal care due to this being a possibly hidden pregnancy. She had her first pregnancy while under twenty, the family were in poverty, and were bed-sharing. In previous pregnancies, efforts to persuade his mother to give up smoking were unsuccessful and Billy's sibling had asthma.

7.49 They are said to have received safe sleep advice from the Neo Natal Unit and Health Visitor but nothing to suggest that this was anything other than generic advice that would be given to low risk families. The manner by which the advice was given may not have been appropriate for this family. The mother and father do not recall be given any such advice.

8. Analysis

8.1 This thematic review relates to the national and local prevalence of co-sleeping related deaths, the national and local guidance, how advice and information is shared in Southampton and, crucially, four tragic deaths of babies who had been sleeping with one or more of their parents.

8.2 What it cannot be is a detailed analysis of the causes of co-sleeping deaths nor draw any definitive conclusions as to how the health and social care services in Southampton prepare and support parents to avoid the risks of SIDS through safe sleeping practice.

8.3 From the evidence provided to this review, it is safe to conclude that parents of most children born in Southampton receive advice on safe sleeping. Although some may not hear or remember it. Given there were four co-sleeping deaths over the two year period examined by the review, the overwhelming majority of babies do not die having been co-sleeping with one or more of their parents and it is probable, although not certain, that most parents receive, understand and adopt the safe sleeping advice they receive.

8.4 That said, four deaths are four too many so this thematic review has examined the factors surrounding their deaths, the national and local picture and suggested some ways to help parents avoid these tragedy going forward.

Figure 1

Risk Factor	Reece	Child A	Child B	Billy
Not in a cot by parents' bed	X	X	X	X
Sleeping with baby on a sofa				X
Sharing with a smoker	X		X	X
Sharing with person who has consumed alcohol				
Sharing with person who has taken drugs (legal or illegal)				
Parents in low socio-economic groups	X			X

Parents currently abuse alcohol or drugs				
Young mothers with more than one child	X			
Premature infants and those with low birthweight		X	X	X

8.5 Figure 1 shows how each of the risk factors cited above applied to each of the babies who died. Unsurprisingly, none were in a cot but what does stand out is that three out of the four were premature with low birthweights, three were sharing a bed with a smoker and at least two came from low socio-economic groups.

8.6 The three who were premature and low birthweight all spent varying degrees of time in the UHS NNU. Whilst Reece did not, there was close midwifery oversight of his birth and discharge given that he was a child in need.

8.7 There is evidence of some level of disengagement in three out of the four cases, albeit in respect of Child B this was after his birth, while with the other two it was both before and after.

8.8 Whilst not published risk factors, it is noteworthy that all four were white, British boys and three out of the four had siblings who had previously been on Child Protection Plans. Reece himself had been on a Plan as an unborn baby but stepped down to child in need before he was born.

8.9 While Reece, Billy and Child B had siblings previously on Plans, only Reece and Billy presented with ongoing concerns and their deaths rightly led to SCRs while the other two, rightly, did not.

8.10 Only Reece's mother could be categorised as being young with more than one child but Billy's mother was 19 when she had her first child. Child B's mother was 17 when she had her first child and Child A's mother was 19 but he had no siblings. Paragraph 4.4 explains the increased prevalence of SIDS among those whose mother are under twenty.

8.11 Three of the four children were receiving universal health visiting services. The fourth was on Universal Plus but that did not make any difference to the support provided. Only one was eligible for FNP but his mother declined this service antenatally so was transferred to universal services.

8.12 While only one baby was sleeping on a sofa, two others were not on suitable beds; one on an airbed (although that is disputed) and one on a bed-shaped and sized piece of foam. As well as around co-sleeping, clear advice should be given as to suitable mattresses and bedding as inappropriate choices can elevate risk.

8.13 In a 2017 study by the Worcester Polytechnic Institute[16], it was found that in one focus group all mothers admitted to bedsharing, especially when they had multiple children and were exhausted. These mothers were aware of the recommendations, yet succumbed to fatigue. The education level of this group suggested that even highly educated parents do not always follow recommendations. If parents bedshare with their baby in an adult bed that is full of pillows and blankets, the risk is higher than if the mother and infant sleep in a bed with no soft bedding. Therefore, parents should be educated on ways to reduce SIDS while bedsharing since some are going to do it anyway.

8.14 Fatigue did not overtly feature in the four deaths subject of this review. The main reasons for co-sleeping in those cases were (arguably) space/ bed availability,

[16] https://web.wpi.edu/Pubs/E-project/Available/E-project-121217-163202/unrestricted/WPI_Infant_Sleep_Safety_CPSC_17_Report.pdf

parental ill health and baby's ill health. However, three of the four children had siblings and this almost certainly would have induced fatigue that would only have exasperated any other underlying stresses.

8.15 Sometimes parents will resort to co-sleeping at times of increased stress or worry, for example if their baby is ill, if it is not sleeping or if it is disturbing other siblings. Co-sleeping advice should reflect these realities and suggest safer alternatives as a contingency to dissuade parents from resorting to unsafe practices. GPs and Health Visitors can help with this as they would often be the parents'' first port of call.

8.16 The 2017 study (ibid) found that information between different medical professionals was often inconsistent and confusing. It found that many health care providers were concerned mostly with their area of focus rather than considering the overall welfare of "the entire child." Whilst there is no suggestion that in Southampton the advice is differentiated across the various health providers consistent, reliable and evidenced advice should be provided across the whole system. This should start antenatally and continue through to postnatal and health visiting care, including through primary and children's social care where such contact exists.

8.17 Two of the parents do not remember being provided with safe sleeping advice (although one of these disputes that her baby was co-sleeping with her).

8.18 There certainly appear to be systems in place in both hospital midwifery, Neo Natal Unit and health visiting to provide parents with advice on safe sleeping but not in primary care or community midwifery antenatal services.

8.19 Each of these children were either in NNU or, in the case of Reece, were subject to enhanced oversight as he was a child in need. The advice provided appears generic and not targeted in any way. Providing it through a QR code or in the 'red book' relies on parents being attentive or motivated enough to seek it out. Most probably are, but not all. At least two of these families had a track record of poor engagement so it is reasonable to assume they may need more signposting to advice that just a QR code.

9. Recommendations

9.1 Each of these deaths was a tragedy and each had unique features. Some, however, shared issues that can be clustered under the following themes:

- Recognition, understanding and mitigation of risk factors
- Quality and targeting of co-sleeping guidance
- Vigilance of sleeping arrangements
- Public awareness

9.2 The following recommendations seek to address these themes:

Recommendation 1

Commissioners of health and housing providers, and Children's and Families Services, should develop service expectations that in working with, treating or supporting parents with a child (or children) under one year old, providers and professionals pay due regard to the risks of Sudden Infant Death Syndrome and they ensure that workforce development and supervision arrangements equip and support staff to recognise, advise upon and mitigate risks in partnership with the family.

Recommendation 2

Hospital and other health professionals should be provided with the training and resources to deliver effective guidance to both parents, on each discharge, to reduce the risk of SIDS. This should include mattress and bedding safety, exposure to passive smoking, drugs, alcohol and management of babies with temporary or chronic respiratory illnesses. There should be graduated guidance aimed at those from standard risk through to high risk of SIDS and should be available in a range of ways so it is easily accessible. The fact, content and method of the advice given should be recorded and passed on to primary care, community midwifery and health visiting services to ensure they are equipped to emphasise it and confirm it is being put into practice.

Recommendation 3

Children and Families Services and Solent Heath Care should collaborate on their safe sleep training programmes. These new provisions should be developed to empower professionals from their own agencies, and others including primary care, to provide consistent and targeted advice and support tailored to families' needs and preferred method of receiving clinical advice.

Recommendation 4

Parents of all babies, particularly of those who are in, or may fall into, high risk groups should receive accessible, personal and targeted advice and guidance which includes, not only the basic advice provided to all parents but also a discussion about where the baby will be sleeping and how they can reduce any evident risks. This should be provided by community services, primary care and as part of the hospital discharge process, whether that be from midwifery, NNU or the children's wards.

Recommendation 5

Community midwives, health visitors, community nurses and social workers should undertake home safe sleep assessments so they can support all parents, but particularly those assessed as high risk of SIDS, to make safe decisions around lifestyle and sleeping arrangements. This may include physically checking where a child is sleeping, or may sleep, and advise accordingly where such opportunities arise.

Recommendation 6

Housing providers and CFS should ensure that, prior to vulnerable families moving into supported accommodation, an assessment is made as to the suitability and safety of that accommodation, as well as its fixtures, fittings and furniture, for the children and family concerned.

Recommendation 7

Southampton LSCB, in conjunction with Public Health should commission a high profile internal and external public health campaign aimed at making safe sleeping everyone's responsibility. It should raise the wider understanding of SIDS risk factors and how parents, professionals and advertisers, can reduce those risks with the aim of supporting parents in making wise decisions around their babies' sleeping arrangements and where they can access information or support should they need it.