Co Sleeping Thematic Review Briefing

Southampton Local Safeguarding Children Board LSCB

The Background

In June 2018, Southampton Local Safeguarding Children Board (LSCB) 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. The timing of the review was such that it could not report until the second of these SCRs had concluded. Each of these deaths was a tragedy and each had unique features.

Summary of review

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 (Reece, Billy, Child A and Child B) who had been sleeping with one or more of their parents.

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. 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. Safe Sleep advice is given but not always 'heard' by parent's and/or carers.

Identified Risk Factors

The table below shows each of the risk factors 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.

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

The Review

This thematic review and analysis of common issues regarding co-sleeping looked across the two Serious Case Reviews of 'Reece' and 'Billy' plus any identified CDOP cases with modifiable factors from 1st April 2016 to 1st April 2018. Relevant background and contextual information regarding key factors and significant events about the families that was known or knowable by the agencies involved was requested as part of the process. A facilitated practitioner's workshop and a panel meeting were convened to consider the findings and learning for the review. The reviewer also engaged with the families as part of the review process.

The Findings

1. There is **evidence of some level of disengagement in three out of the four cases.**

2. Whilst not published risk factors, it is noteworthy that **all four babies were white, British boys and three out of the four had siblings who had previously been on Child Protection Plans**.

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

4. 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.

5. **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 Family Nurse Partnership (FNP) but his mother declined this service antenatally. Following declining FNP, the family were transferred to universal plus health visiting services.

6. 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.**

7. In a 2017 study by the Worcester Polytechnic Institute, it was found that in one focus group all mothers admitted to bedsharing, especially when they had multiple children and were exhausted. The education level of this group suggested that **even highly educated parents do not always follow recommendations.** Therefore, **parents should be educated on ways to reduce SIDS while bedsharing since some are going to do it anyway.**

8. **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, parental ill health and baby's ill health.

9. 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.

10. 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 care and children's social care where such contact exists.

11. **Safe Sleep 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.

Useful links for good practice

- Link to Billy SCR Briefing (to be added)
- Link to Reece SCR Briefing (to be added)
- LSCB Website
- 4LSCB procedures (Click relevant geographical area)
- The Lullaby Trust Safe Sleep Advice
- Safer Sleep: Saving Babies Lives – a professional guide
- NSPCC Case Review Summary – Working with parents of children under 2 yrs
- Working Together 2018
- The Family Approach Toolkit