# GSCP Rapid Review Practice Briefing: Co-sleeping and Safer Sleep for Babies

Gloucestershire Safeguarding Children Partnership

Each year around 200 babies will die unexpectedly[1] before their 1st birthday. The sudden unexpected death of a baby, when there is no apparent cause of death, is referred to as sudden unexpected death in infancy (SUDI). Unexplained death in infants under 1 is more likely to affect children in the most deprived neighbourhoods (42%) than those least deprived (8%). There are strong associations with low birthweight, prematurity, multiple births, larger families, admission to a neonatal unit, maternal smoking during pregnancy, young maternal age and parental smoking and drug use.

There is a strong link between SUDI and sleeping arrangements. It is known that there is an association between co-sleeping with a baby in a bed, chair or sofa and SUDI. Risk increases where parents co-sleeping with their baby are smokers, drink or have drunk alcohol or have taken prescription or non-prescription drugs.

## The Rapid Review

At the end of 2023 a rapid review[2] was convened with multi agency Partners to examine the circumstances leading up to the death of an under 1 year old baby, who lived at home with their mother and Father. The baby was found unresponsive likely having co-slept in bed with their parents. The Baby was subject to a child protection plan[3] and Interim Care Order[4] at the time.

## The Baby's Story showed:

- There were known contextual and current risk factors within the family situation, including parental alcohol and drug use.
- Maternal mental health issues and patterns of domestic abuse.
- Evidence of parental reluctance when working with agencies.
- Repeat patterns of harm and poor quality of parenting, with limited abilities or motivation to sustain change.
- A difference in professional opinion which was significant in determining levels of risk and whether the baby should remain in their parents' care. This was not discussed as it needed to be in the Court arena to safeguard the baby.

## Practice Strengths:

- There was evidence of health professional's repeated efforts to promote safer sleep for the Baby.
- There were good examples of health systems working well together, for example hospital and community midwife teams and health visiting.
- Children's Social Care (CSC) correctly identified risk and child protection pre-birth procedures were in place.
- CSC appropriately sought legal advice in a timely manner and an interim court order was secured to try to safeguard the new-born baby.

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[1] See the National Child Mortality Database

[2] Insert GSCP guidance on Learning Reviews or take to website

[3] A child protection plan is made when a child is judged to be at risk of significant harm. The plan will say what the specific risks are and actions that are needed to keep the child safe

[4] An Interim Care Order grants the local authority parental responsibility as evidence has been provided to the courts to suggest a child is at risk of suffering significant harm as a result of the care they receive

## Learning

- It is vital to remain professionally curious in practice and ask the 2nd questions if you have a difference of opinion or are not clear on why a professional has reached a judgement regarding parenting capacity
- It is important to include CAFCASS and the Courts when strengthening working together and when sharing learning from Rapid Reviews regarding practice improvements
- If a parent chooses to co-sleep with their baby, it is important to discuss the reasons for this, including culture and religion and adopt a non-judgemental approach whilst highlighting risk and supporting to make informed choices
- CSC Senior leaders need to address workload capacity issues, especially when practitioners are allocated large sibling groups
- When families move areas at a child protection level, it is important the network of multi-agency professionals ensure a coordinated response to baby's being registered at GP practices.

## Questions for Practice

- Am I aware of the risk associated with co-sleeping and do I feel confident in talking with parents about these to find a safe solution?
- How do I know I am being child focused and what would I do if I saw professional approaches which showed a parental focus to work and over optimistic assessment to parental change?
- Have I considered the contextual history when considering current harms to very young children? Have I paid attention to the vulnerability of babies?
- Do I always consider culture and identity issues when I work with children and families?
- Have I understood a parent's history and considered adverse childhood experiences, along with any current learning needs? Do I do this in a trauma informed way?
- Am I alert to parental resistance and alienating behaviours, and do I challenge this through open and honest conversations?
- Do I know how to escalate matters if there is a continued difference of professional opinion (insert Escalation Policy)

# Additional Resources

- National Panel Report July 2020 Out of Routine: A review of SUDI where children at risk of significant harm
- Home - ICON Cope
- The Lullaby Trust - Safer sleep for babies, Support for families
- GSCP Procedure Manual

Produced in Partnership with Gloucestershire Child Death Overview panel.

**Gloucestershire Child Death Review**