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## What is multi-agency SUDI prevention?

- All families should receive universal SUDI prevention / safer sleep info before and after birth, but…
  - Some do not engage with antenatal care or health visitor appointments
  - Some forget the safer sleep info they have been given or don't tell partners or other carers
  - Some are unable to implement the guidance due to lack of resources, temporary living arrangements, disruptions or other family circumstances
- Other professionals often have more frequent access to these families and better opportunities to provide information and support
- Multi-agency SUDI prevention involves offering all professional staff the information and skills to observe, listen, signpost and intervene to prevent sudden unexpected infant deaths

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## The SUDI Prevention Project

The Multi-agency SUDI Prevention Project aims to eliminate the unexpected deaths of babies (under 1 year of age) in Northumberland.

It is jointly funded by Northumberland County Council, Northumberland Family Hubs, and Northumbria Healthcare NHS Foundation Trust

Led by:

Professor Helen Ball, Durham Infancy & Sleep Centre, Durham University

Ms Carla Anderson, Public Health Midwife, Northumbria Healthcare

Mr Jon Lawlor, Public Health Consultant, Northumberland County Council

The project aims to implement a multi-agency workforce approach to SUDI prevention in vulnerable families. This involves training local authority staff, NHS staff, and staff of partner services who may encounter vulnerable families with babies.

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## Why Northumberland

SUDI (Sudden Death in Infancy) is now more likely to happen in some families than others

Deaths occur most often in families living in impoverished circumstances with multiple risks or vulnerabilities

In Northumberland 17.6% of all children are living in absolute poverty (n=9078 children in 2022 where families received less than 60% of the median income established 2010-11). UK average =15.3%.

In Northumberland approximately 5 SUDIs occur per year and this rate has not declined for several years.

**Most SUDIs are preventable**

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## Three strands of training

Strand 1 is for workforce members staff who go inside homes, who talk to new parents, or who help in a crisis.

- They will keep 'Eyes on the Baby': observe, listen, nudge, and refer/report

Strand 2 is for workforce members who provide direct support to vulnerable families

- They will raise awareness of and reinforce SUDI prevention: explore, remind, support and refer/report

Strand 3 is for health professionals who are involved in the routine or emergency care of pregnant and post-partum women and babies

- They will offer universal and targeted safer sleep guidance: inform, understand, guide, refer/report, and respond to concerns from staff in strands 1 & 2 as needed

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## This is Strand 3

This training is for health and care professionals who are involved in the specialist routine care of pregnant and post-partum women* and babies, or provide emergency care for parents and babies:

| | |
|---|---|
| Health Visitors / Home Visitors | Family Nurse Partnership Staff |
| Midwives & Maternity Care Assistants | Infant Feeding Leads |
| Community Midwives | Smoking Cessation Services |
| Neonatal Care Staff | Perinatal Mental Health |
| General Practitioners | Paediatricians |
| Advanced Nurse Practitioners | Paediatric OTs & PTs |
| Advanced Clinical Practitioners | Public Health Staff |
| Physicians Assistants | Children's Social Workers |
| PCN Mental Health Workers | |

*With acknowledgement that not all pregnant and birthing people identify as women.

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## Aim of this training

To update practitioners with specialist access to pregnant / postpartum women and infants to:

a) Inform families about SUDI and SUDI prevention
b) Understand recent changes to UK SUDI guidance
c) Increase confidence in understanding of evidence for guidance
d) Guide families by providing tailored information
e) Respond to concerns raised by non-specialist workforce

When: During antenatal & postnatal consultations

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## This training covers

**Part 1: Safer sleep for all babies**
- Universal provision and underpinning evidence
- New safer sleep discussion tools

**Part 2: Understanding co-sleeping & bed-sharing**
- Why and how UK guidance has changed
- Risk minimisation and tailored guidance (difficult conversations)

**Part 3: Targeted prevention for vulnerable and at-risk families**
- Vulnerable families & SUDI
- Resources
- Evaluation

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## Part 1

Safer Sleep for All Babies (Universal provision)

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## What are SUDI and SIDS?

SUDI = Sudden Unexpected Death in Infancy
- The death of a baby which was not anticipated as a significant possibility 24 hours before the death.

SIDS = Sudden Infant Death Syndrome (retrospective classification)
- "[T]he sudden unexpected death of an infant <1 year of age, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history" (Krous et al 2004)

SUDI encompasses SIDS but also includes accidental deaths, homicides (rare), and sudden onset illnesses causing catastrophic collapse


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## SIDS & SUDI Prevention in UK

Over 30 years SIDS in England & Wales declined from 2.3/1000 to 0.27/1000

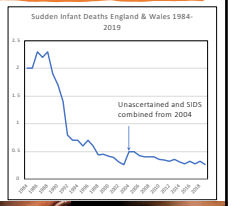
Today's new parents have no personal experience of SIDS or the SIDS-reduction campaigns of the 1990s

Consequently they do not find 'reduce the risk' compelling; they need specifics

Parents described the previous long list of safe sleep 'do's and don'ts' as overwhelming and difficult to implement.

They objected to guidance without explanation, and rejected idealised advice

They want to know what is safer when safest is unattainable.

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## Preventing the unexpected?

- As SUDIs are unexpected and SIDS have no underlying cause to tackle, how do we prevent them?
- We need comparisons with babies who don't die to compare the differences: **case-control study design**
- Compare characteristics of SIDS babies (cases) with control babies matched for key criteria
- Factors that are **associated** with being in the SIDS group but not control group = **risk factors**


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## Case-control studies have limitations

- Case-control studies are the most appropriate method for identifying factors involved in SUDI
- BUT are rated as 'Low Quality' on the scale of medical evidence – chances of bias are high
- Normally used for generating hypotheses, not formulating policy
- We can't test SUDI hypotheses using RCTs…
- So use case-control study evidence with caution as they can produce red-herrings or highlight risks that are more complex than they seem

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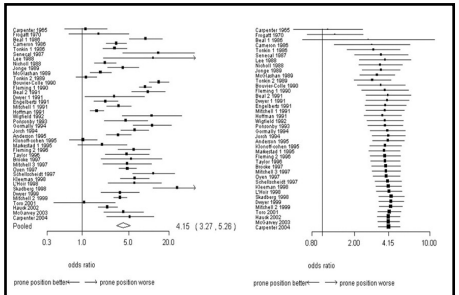


Gilbert et al (2005) Infant sleeping position and the sudden infant death syndrome: systematic review of observational studies and historical review of recommendations from 1940 to 2002 . *IJE* 34(4):874-888.

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## Worldwide campaigns

- Case-control studies conducted in many countries
- All confirmed the association of SIDS and prone sleep
- No evidence of choking risk (often a concern of grandparents)
- Back to Sleep campaigns launched around the world
- We still don't know why supine position is protective!


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## Lots of other associations identified

- Smoking
- Prematurity
- Head covering
- Lone sleep
- Overwrapping / overheating
- Soft bedding / surfaces
- Pacifiers / dummies
- Formula feeding
- Bedsharing / co-sleeping
- And more…


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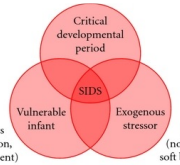
## The Triple-Risk Model

SIDS occurs at the intersection of three overlapping factors.




Intrinsic risk factors (genetic predisposition, risks during development)

Extrinsic risk factors (nonsupine sleep position, soft bedding, overheating, . . .)

Filiano, J. J., & Kinney, H. C. (1994). A perspective on neuropathologic findings in victims of the sudden infant death syndrome: the triple-risk model. Neonatology, 65, 194–197.

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## Intrinsic risk factors

Increased risks that are present at birth and cannot be reduced postnatally

Parents whose babies have intrinsic risks need to know so they can be extra vigilant

- Prenatal exposure to drugs, especially nicotine and alcohol
- Premature birth
- Low birth weight

Some intrinsic risks are invisible…

- Some genetic polymorphisms (variants)
- Brainstem anomalies

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## Smoking

- Studies find around a third of SIDS deaths could be prevented if no babies were smoke exposed in pregnancy
- Babies whose mothers smoked during pregnancy have an abnormal response to hypoxia and hypercarbia as well as a reduced arousal response.
- There is a dose-dependent relationship, with an increasing risk of sudden death with greater cigarette consumption.
- The risk is reduced in mothers who quit or reduce their smoking in pregnancy.
- Maternal smoking in pregnancy is therefore a modifiable risk factor (albeit a complex one).
- Research studies have not yet examined e-cigarettes and SIDS.

Anderson TM, Lavista Ferres JM, Ren SY, Moon RY, Goldstein RD, et al. Maternal smoking before and during pregnancy and the risk of sudden unexpected infant death. *Pediatrics.* (2019) 143:e20183325.

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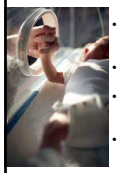
## Prematurity



- Preterm babies are 2-3 times more likely to experience SIDS than term babies (US data).
- Preterm babies have an immature central respiratory control centres, hindering their ability to respond to respiratory challenges.
- Studies have found lower adherence to safer sleep guidelines among parents of preterm than term infants.
- Maternal perceptions of the special needs and vulnerabilities of their preterm babies meant that sleep safety recommendations seemed less important.
- Preterm infants are disproportionately born to women living in socio-economically deprived circumstances and to women who consumed drugs, alcohol, tobacco products in pregnancy.

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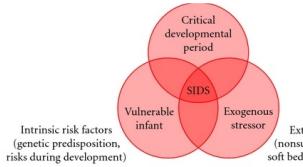
## The Triple-Risk Model

SIDS occurs at the intersection of three overlapping factors.




Filiano, J. J., & Kinney, H. C. (1994). A perspective on neuropathologic findings in victims of the sudden infant death syndrome: the triple-risk model. Neonatology, 65, 194–197.

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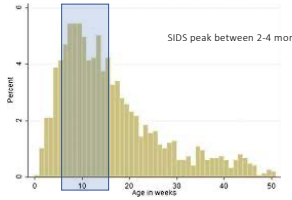
## Critical developmental period

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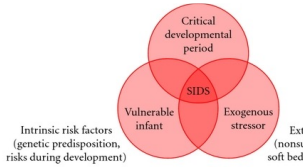
## The Triple-Risk Model

SIDS occurs at the intersection of three overlapping factors.




Filiano, J. J., & Kinney, H. C. (1994). A perspective on neuropathologic findings in victims of the sudden infant death syndrome: the triple-risk model. Neonatology, 65, 194–197.

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## External risk factors

Also called **'Exogenous stressors'** = sleep environments that can physiologically stress a vulnerable baby triggering a homeostatic malfunction ('irreversible cascade') from which the infant cannot recover.

Healthy non-vulnerable infants arouse from sleep and mount a physiological response to an exogenous stressor, but vulnerable infants may not.

Key pathways involve:

- Thermoregulatory (overheating) challenges
- Cardio-respiratory (breathing) challenges

Ramirez JM, Ramirez SC, Anderson TM. Sudden Infant Death Syndrome, Sleep, and the Physiology and Pathophysiology of the Respiratory Network. In: Duncan JR, Byard RW, editors. SIDS Sudden Infant and Early Childhood Death: The Past, the Present and the Future. Adelaide (AU): University of Adelaide Press; 2018 May.

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## Prone sleep

Prone sleep (sleeping on front) is associated with a 4.15x increased chance of SIDS compared to non-prone sleep

Babies under 6 months should be placed on their back to sleep on a clear flat surface

This guidance has been the most successful SUDI reduction guidance around the world over the last 30 years

**Small babies have very heavy heads and weak necks. They can get stuck with their airways blocked by soft surfaces which can trigger SIDS or suffocation**

Once babies can roll both ways it is OK for them to sleep on their front

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## Overwrapping / overheating

- The amount of bedding and clothing (insulation) was significantly higher for babies who died from SIDS than controls, and that cases were more likely to have had the heating on all night.
- Several factors such as fever from infection, prone sleeping, over-wrapping or bedclothes covering the head, can affect thermal balance by making a baby too hot or reducing their ability to lose heat.
- A room temperature of 16-20°C, combined with light bedding offers a comfortable and safe environment for sleeping babies.
- Baby sleep bags are often recommended to avoid overwrapping and head covering.

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## Head-covering

- A greater proportion of infants whose deaths are designated as SIDS are found with their head covered with bedding.
- The head is an important source of heat loss for a normal baby.
- One study reported that the risk of SIDS was 2.5 times when the infant's head or face was covered with bedding.
- The use of loose bedding which covers the head is an independent risk factor, and is a key reason why it is advised to avoid using duvets, pillows and bumpers in infant sleep environments.
- Babies should not wear hats for sleep during the day or night as they can increase the risk of SIDS by more than three times.

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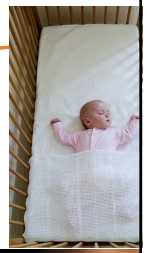
## Feet-to-foot

In the UK 'feet-to-foot' guidance was introduced to help parents remember to put their baby's feet at the foot of the cot to stop them wriggling down under the covers.

This guidance was a pragmatic suggestion intended to keep the head from being covered, a risk which has previously been seen in SIDS victims in early case-control studies.

But, there have been no case control studies that have examined whether 'feet to foot' worked as a SIDS reduction message.

Feet-to-foot is mentioned, but no longer emphasised due to the lack of clear evidence, and the widespread use of sleeping bags that now makes it less easily understood.



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## Soft bedding / surfaces

A US case-control study found that a soft sleep surface (defined as the infant's head sinking one inch or more) led to a five-fold increase in the risk of SIDS

This same study showed that placing infants to sleep in the prone position may be especially dangerous when combined with soft sleep environments

The combination of the prone position for sleeping and the presence of a soft bedding surface increased the chance of SIDS over 20 times!

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## Lone sleep

Multiple studies have found that leaving babies to sleep in a room on their own increases the chance of SIDS for both night-time and day-time sleep

Babies should sleep in the same room as their parents/carer both day and night

One case control study found the risk of unsupervised sleep during the day was almost double that of unsupervised sleep at night

A travel cot, Moses basket, playpen, or carrycot is suitable when other safer sleep guidance is followed.

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## Dummies / Pacifiers

Multiple studies have found dummy use to be a protective factor, although the mechanism remains unclear

Two studies have found that if an infant who is accustomed to a dummy is not given one on a particular occasion, the risk of SIDS increases, so if a dummy is used it should be given for every sleep period

These studies found no increased risk for babies who never used a dummy

It is not UK guidance to start giving a dummy to prevent SIDS/SUDI, but if one is given it is important to be consistent

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## Infant formula

Multiple studies have found that breastfeeding is associated with lower risk of SIDS

A meta-analysis of 23 studies found that formula-fed infants had a SIDS rate twice that of breastfed infants

Most recently Thompson et al (2020) found any breastfeeding for 2 months or more was protective, with greater protection seen with increased duration

Hauck, F. R., Thompson, J. M. D., Tanabe, K. O., Moon, R. Y., & Vennemann, M. M. (2011). Breastfeeding and Reduced Risk of Sudden Infant Death Syndrome: A Meta-analysis. *Pediatrics*, 128(1), 103–110

32

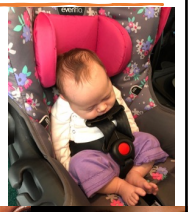
## Other issues – Car Seats

There is an increased chance of SUDI when car seats are used outside of the car. Some car seat deaths were due to strangulation from straps.

Some deaths have been classified as SIDS, and others as positional asphyxia caused by airway obstruction due to extreme flexion of the infant head (chin to chest) in an unsupported seated position.

This can occur in car seats, pushchairs, swings and bouncers.

Encourage parents to avoid leaving babies in car seats when not travelling in the car, and to lie them in a clear flat space.



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## Other issues -- Swaddling

Swaddling immobilises babies which has pros and cons in terms of SIDS

Placing a swaddled baby prone has been clearly shown to increase SIDS risk, but swaddling a supine infant is less clear. A meta-analysis of 4 previous studies found no association but with borderline statistical significance

Swaddling can prevent head-covering, but also decreases arousability. Babies should not be swaddled when bed-sharing. Swaddling should cease before babies are able to roll.

More research is needed to understand whether swaddling infants who sleep supine increases SIDS risk

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## Other issues -- Slings

There is little research evidence to inform understanding of the risks of SIDS when babies sleep in slings, wraps or structured carriers.

Two small case series have reported infant deaths in certain types of carriers, suffocation/positional asphyxia being the primary cause of death – bag slings were particularly implicated.

Parents are advised to follow the TICKS guidance for sling use provided by the UK Sling Consortium which ensures babies are unable to 'slump' inside a sling or carrier.

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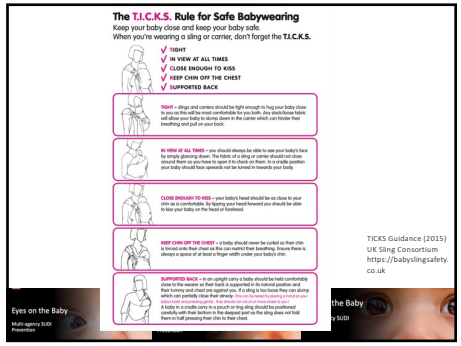


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## Nests, Pods and other Products

Many parents purchase or are gifted pods or nests for their baby to sleep in – however these are not clear flat surfaces and are not recommended for safer sleep

Manufacturers warn these products should not be used unattended, yet they are often placed in cots for babies to use during the night

Parents argue babies are more comfortable and sleep 'better' in them. But 'deeper sleep' for young babies is associated with multiple SIDS risks

Beware of appealing claims and use caution


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## Safer Sleep Guidance for All

Aims to:

- Provide guidance consistent with NICE(2021) recommendations, including parents' right to make an informed choice
- Streamline guidance to focus on the key risks in the UK based on the most up-to-date UK research,
- Be responsive to parents' concerns and help parents understand the reasons for the guidance given,
- Prioritise avoidance of the most hazardous infant sleep practices contributing to the greatest proportion of infant deaths by emphasising:
  a) baby being on his/her back,
  b) in a clear flat sleep space,
  c) smoke free day and night.


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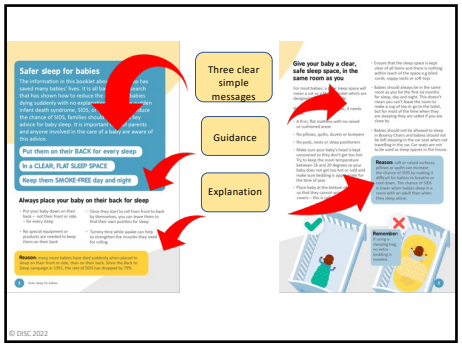


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## What has changed?

We no longer say "The safest place for a baby to sleep is in a cot by your bed"

- Firstly, parents interpreted this guidance to mean the baby should be placed in the bedroom for daytime as well as night-time sleep, increasing the chance of SIDS during daytime sleep.
- It is safer for a baby to sleep in a room where an adult is present than to sleep alone, and most families do not have a cot in their living room. Emphasising a clear flat space for sleep offers parents options.
- Secondly, the assumption that all babies sleep in cots, and indeed that parents' bedrooms and budgets can accommodate a cot reflects a middle-class lifestyle that centres Western cultural assumptions about where babies sleep. 'A clear flat sleep space' eliminates assumptions that can alienate families.

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## Safer Sleep Guidance

- Keeping baby smoke free, and breastfeeding, are both strongly associated with lower chances of SIDS therefore information is provided on these important ways in which parents' behaviours and choices interact with SIDS.
- This guidance has always taken a risk minimisation approach – if you can't quit smoking, reduce consumption, and keep smoke away from the baby (smoke outside).


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## Co-sleeping & bed-sharing

So far all the guidance we have considered relates to babies sleeping alone

The evidence and guidance about bed-sharing and co-sleeping has changed in the UK over the past few years.

In the next section we will consider the research on bed-sharing and co-sleeping in more detail to provide a thorough understanding of the issues involved.

This should allow you to feel confident discussing this with parents and answering their questions.

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# Part 2

Understanding bed-sharing & co-sleeping

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## Understanding bed-sharing

- Bed-sharing & co-sleeping have been poorly understood
- Even the terminology has been variable and inconsistent
- We use **bed-sharing** to refer to **baby and parent sleeping together in a bed**
- We use **co-sleeping** to mean **baby and anyone sleeping together anywhere**
- Bed-sharing is NOT when carer is awake and feeding

Knowledge about why, when and how bed-sharing and co-sleeping happens has improved substantially over past 30 years

Information about the risks associated with co-sleeping and bed-sharing have become clearer over the past decade

Risks are not uniform across all families and contexts

Patterns of risk vary from country to country -- guidance is location specific

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## Understanding bed-sharing

Sleeping with the baby is a common parenting practice. Why?

Because humans have mammal babies!

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## Understanding human babies

- Humans produce single infants, born with well developed internal and sensory organs (see, hear, call) = precocial
- Lactation characteristics of precocial mammals: milk = low fat/high sugar, infants need to feed frequently
- Poorly developed neuro-muscular control = unable to follow or even cling because typical brain growth cannot be completed prior to birth
- Parents must maintain close contact, feed frequently day and night. Contact important for warmth, safety, physiological regulation.
- Sleeping together is what babies expect!

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## Why do parents bed-share /co-sleep?

Systematic Review 2014:

- Breastfeeding was the most commonly cited reason for bedsharing (26 studies); bedsharing was cited as an easy and convenient way to manage frequent night-time feedings; mothers reported not having to 'fully waken' to breastfeed and that preservation of maternal sleep was especially important at return to work.

1) breastfeeding, 2) comforting, 3) better/more sleep, 4) monitoring, 5) bonding/attachment, 6) environmental concerns, 7) crying or unsettled baby, 8) tradition, 9) disagree with danger, 10) maternal instinct.

Salm Ward, T. C. (2015). Reasons for mother-infant bed-sharing: a systematic narrative synthesis of the literature and implications for future research. *Maternal and Child Health Journal*, *19*(3), 675–690.

47

## Bed-sharing is a cultural practice

Most parents have deeply-rooted beliefs about infant care – cultural, religious & personal.

Guidance on the safest position for infant sleep is very different from advice to avoid bed-sharing as this is often part of parents' **coping strategy**, their **personal beliefs** or their **parenting values**, not just an infant care practice.

Telling parents to change these beliefs challenges their values and those of their community – dismissed as culturally or personally irrelevant.

This is one reason efforts to stop bed-sharing are so contentious. Parents dismiss dogmatic recommendations that they don't agree with, or can't comply with.

LE Volpe, HL Ball, JJ McKenna (2013) Night-time parenting strategies and sleep related risks to infants. *Social Science and Medicine* 79: 92-100.

48

## Why do parents bed-share /co-sleep?

**Proactive / Planned:**

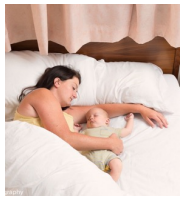
- Ease & convenience of night-time breastfeeding
- Enjoyment of close contact with infant
- Family Bed ideology

**Reactive / Unplanned:**

- Lack of space or suitable furniture
- Anxiety re. infant health or safety
- To settle a fractious baby

**Accidental / Unintentional**

- Exhaustion, alcohol, drugs, medications



Ball, H. L. (2002). Reasons to bed-share: Why parents sleep with their infants. *Journal of Reproductive and Infant Psychology, 20*(4), 207–221.

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## Understanding bed-sharing

70-80% of UK breastfeeding mothers sleep with their babies

Regular bed-sharers with babies under 6 months are non-smokers, breast-feeders, with higher education

A fifth of UK babies bed-share on any given night

UK Asian families are 4x more likely to bed-share than White UK

White British families 5x more likely to co-sleep on a sofa (much more dangerous)

Most babies change sleep location during the night

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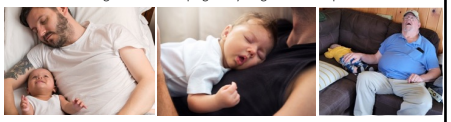
## Bed-sharing / co-sleeping is varied and complex

Bed-sharing can be done in safer, riskier, and downright dangerous ways

People sleep with their babies for positive reasons, negative reasons, and without thinking

Parental knowledge about co-sleeping safety ranges from in depth to no clue!



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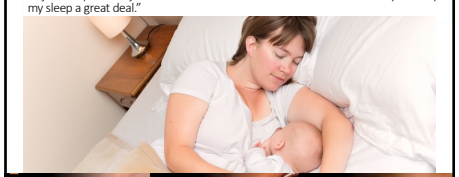
## Bed-sharing is a way of coping

"If he's having a night where he wants to nurse a lot I'll put him in bed with me and I'll just sleep and he just latches on when he wants to and it doesn't really interrupt my sleep a great deal."



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## Bed-sharing supports breastfeeding

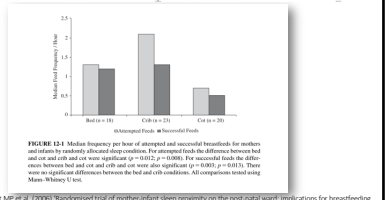


**FIGURE 12-1** Median frequency per hour of attempted and successful breastfeeds for mothers and infants by randomly allocated sleep condition. For attempted feeds the difference between bed and cot and crib and cot were significant ($p = 0.012$; $p = 0.008$). For successful feeds the differences between bed and cot and crib and cot were also significant ($p = 0.003$; $p = 0.013$). There were no significant differences between the bed and crib conditions. All comparisons tested using Mann–Whitney U test.

Ball HL, Ward-Platt MP et al (2008) 'Randomised trial of mother-infant sleep proximity on the post-natal ward: implications for breastfeeding

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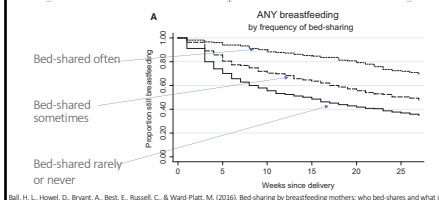
## Bed-sharing supports breastfeeding




Ball, H. L., Howel, D., Bryant, A., Best, E., Russell, C., & Ward-Platt, M. (2016). Bed-sharing by breastfeeding mothers: who bed-shares and what is the relationship with breastfeeding duration? *Acta Paediatrica, 105*(6), 628–634.

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## How do mothers and babies bed-share?

Characteristic bed-sharing position adopted by breastfeeders described 2006

Involves close proximity, mutual orientation, protective 'C', sleep synchrony

- Baby at breast-level - easy access to feed
- Baby flat on mattress away from pillows
- Mother's body constrains baby – can't move up or down bed
- Mother controls height of bed covers over baby
- Mother cannot roll on baby
- Mother monitors temperature and breathing

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## Breast-feeders resist bed-sharing 'bans'

Strong association between breastfeeding and infant sleep location. The majority of mothers who breastfeed bed-share. Facilitates night-time feeding, and helps maintain milk supply. Breastfeeding bed-sharers strongly resist anti-bed-sharing campaigns.

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## Co-sleeping & bed-sharing

- Co-sleeping is a complex parental behaviour that can be practised more or less safely
- Bed-sharing is associated with positive and negative infant outcomes. Context of sleep environment and motivations/beliefs of parents are key.
- Advice to avoid bed-sharing is very contentious. Parents dismiss dogmatic recommendations that they don't agree with, or can't comply with.

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## Co-sleeping & bed-sharing

Evidence is clear that certain situations increase the dangers to babies:

- Co-sleeping with a baby on a sofa
- Sleeping with a baby following consumption of any drugs or alcohol
- Sleeping with a baby if a cigarette smoker
- Sleeping with a premature or low birthweight baby
- Unplanned co-sleeping/bed-sharing is more risky than intentional and planned bed-sharing in a safety-proofed adult bed. In the absence of hazards there is little to no evidence of increased risk.

Guidance must be balanced to minimise risk while encouraging informed choice. This encourages open discussion, information sharing, and planning ahead.

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## ABM Protocol on Breastfeeding & Bed-sharing

Bedsharing promotes breastfeeding initiation, exclusivity & duration

Can be a risk when carried out under hazardous circumstances

Discussions about safe bedsharing should be incorporated into guidelines for pregnancy and postnatal care

Recommendations regarding bedsharing should take into account the mother's knowledge, beliefs and preferences, and acknowledge the known benefits as well as the risk

Ending stigma around bedsharing and educating all parents about safe bedsharing have the potential to reduce infant deaths


ABM Protocol

Bedsharing and Breastfeeding: The Academy of Breastfeeding Medicine Protocol #6, Revision 2018

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## Tailoring bed-sharing messaging

- Messages should be tailored to individuals and their specific family circumstances
- Equity of safe sleep messaging (not the same as equality!)
- Families need to know why their baby may be at increased risk of SUDI with bed-sharing/co-sleeping and why they are receiving particular guidance
- Families should have their views and beliefs respected

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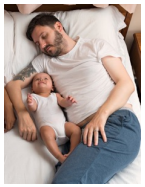
## Discussing safe sleep with all

- Partners and other family members should be involved in bed-sharing discussions
- Ball et al. 2000 – Triadic co-sleeping common, with fathers expressing fear and trepidation about safety
- Co-sleeping has benefits for dads:
  - Helps encourage involvement in night-time caregiving
  - Ameliorates distancing effects felt by fathers outside the breastfeeding relationship
  - Bonding time for those who are away from baby for most of the day
- But safe sleep is often given less importance by caregivers when routine is disrupted e.g. weekends when partner is home, so think ahead (Pease et al 2017)



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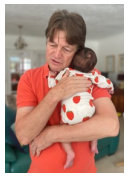
## Discussing safe sleep with all

- Who else might be influencing care and sleep decisions?
- 'Can't fight culture and grandma' (Stiffler et al. 2020)
- Aitken et al (2016) USA survey with grandparents who care for infant grandchild
  - When baby staying at grand-parents house 44% reported following safe sleep guidelines, at baby's house 58% reported following guidelines
- Ensure grandparents know the hazards of falling asleep with baby on a sofa or arm-chair
- Encourage grandparents/extended family to be 'Eyes on the Baby' if parents are tired, baby is pre-term etc.



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## Think about your language

- The way that we talk to families about infant sleep can influence the way they think and act
- Using normalising language can help you discuss parenting and sleep practices without families feeling pressured or judged


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## Talking matters

50% or more of UK babies will spend some time sleeping with one or both parents by 3 months of age.

They may do this frequently, occasionally, just once. They may plan to do this, do it spontaneously or do it accidentally. They may think they will never do it.

Talking about where babies sleep with ALL parents and carers matters, because everyone needs info on what makes sleep locations risky, and how to make them safe and what to avoid.

'Never Bed-share' messages prevent discussion, encourage parents to hide their behaviour, and means families who need info don't get it.

Also 'Never Bed-share' messages mean practitioners do not receive appropriate training or gain experience using their professional judgement on this issue.

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## Safer Sleep Guidance

- Co-sleeping is a complex behaviour associated with SIDS and accidental infant deaths, that can be practised more or less safely.
- Happens for a wide range of reasons: "co-sleeping is both too common and too complex to apply a simple ban" .
- Encourages open discussion, information sharing, and planning ahead.
- Offers risk minimisation guidance to avoid the most dangerous scenario and make bed as safe as possible


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## What has changed?

- We no longer advise 'Never Bed-share' – we aim to discuss with all parents
- In 2014 NICE moved SIDS messaging towards informed parental choice
- In 2021 NICE reviewed the benefits and risks of bed-sharing and recommended parents of babies are given advice about safety when sharing a bed with their baby at their first home visits from a midwife and a health visitor. This should include how to keep their baby safe when sharing a bed with their baby and when to avoid sharing a bed with their baby.
- In 2021 RCM produced new guidance that reiterates the same message https://www.rcm.org.uk/media/5713/safer-sleep-guidance.pdf

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## Safer Sleep Discussions


The Safer Sleep Professionals' Guide offers information on:

- non-judgemental conversations,
- personalising information,
- emphasising contextual risks.

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## Safer Sleep Discussions

- Provide families with the information they need to make informed decisions
- This includes meaningful conversations about high-risk situations
- Be clear about risks but non-judgemental
- Use professional curiosity to explore situations and practices
- Safer sleep risk assessment tools or decision tree tools can be helpful.

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## Summary

- All parents need information on safe bed-sharing and most families do it. Emphasise making bed safe and planning ahead. Include partners in planning and safety discussions.
- Parents with babies with intrinsic SIDS risks due to prenatal smoking, premature birth etc. need clear information to understand their babies' risks and why they are especially vulnerable. Bed-side cribs and family support (Eyes on the baby) are helpful.
- Sofa-sharing can be avoided if bed-sharing is not prohibited. Help parents consider 'what if' scenarios to avoid sofa sharing.
- Educate parents on possibility of falling asleep with baby unexpectedly, and hazards of accidental /unplanned bed-sharing: consider a contingency plan / safety net option for the middle of the night.

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## Part 3

Vulnerable / at-risk families & SUDI

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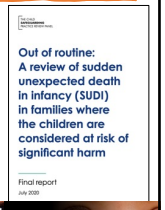
## Which babies are most at risk?

- At least 300 SUDI deaths occur each year in England & Wales, despite dramatic reductions since 1990s.
- Review of 568 serious incidents notified to national Child Safeguarding Review Panel 2018-19, 40 = SUDI.
- Majority of deaths nowadays occur in families from deprived socioeconomic backgrounds.
- Deaths cluster in vulnerable families.
- Risks for SUDI overlap substantially with risks for child neglect & abuse

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## Risks identified

- Unsafe sleep position (front or side)
- Unsafe sleep environment
  - Co-sleeping in the presence of other risks
  - Over-wrapping (head covered, use of pillows or duvets)
  - Soft sleep surface (soft or 2nd-hand mattress)
- Tobacco smoke exposure (pregnancy & environmental)
- Alcohol and drugs (during pregnancy & while co-sleeping)
- Poor postnatal care (late booking and poor antenatal care attendance)
- Low birthweight (under 2,500g) and preterm birth (less than 37 weeks gestation)

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## Most cases are preventable

- Risk factors are well recognised
- Steps parents can take to reduce risk are well known
- Have formed basis for consistent safer sleep messaging for decades
- Although messages may be rigorously delivered families at risk are unwilling or unable accept or implement this guidance.
- Most research studies have found parents knew the guidance but found it unrealistic or implausible
- Or parents had not engaged with ante- or post-natal care and had not received safer sleep information
- 2020 SUDI report recommends 'something needs to change in the way we work with these most vulnerable families if we are to prevent more infants' lives being lost'.

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## SUDI Review Key Findings

- All most all of the 40 cases reviewed involved:
  - Co-sleeping in unsafe environments
  - Parental use of alcohol or drugs
  - Cumulative neglect
  - Domestic violence
  - Parental mental health concerns
- 63% of cases were under 3 months, with a peak at 1 month
- 16 White British, 9 ethnic minorities, 15 ethnicity not given.
- 10 cases = poor housing & overcrowding
- Unrecognised childhood adversity for parents
- Particular situational risks and disruptions to normal routines meant families were unable to engage effectively with safer sleeping advice.

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## Continuum of risk

| Level of risk | Families affected | Risk factors identified |
|---|---|---|
| Background context | All families | General risk factors for SUDI<br>Variations in access to preventative services<br>Fragmentation between providers |
| Predisposing vulnerability & risk | Families with additional needs | Socio-economic deprivation; Poor or overcrowded accommodation; Adverse childhood experience of parents; Parental mental health problems; Alcohol or substance misuse; Ongoing and cumulative neglect; Parental criminal behaviours; Relationship breakdown and/or new partners; Limited engagement with services; Prematurity or other vulnerability of infant. |
| Situational risks and out-of-routine risks | Families with children at risk of significant harm | Temporary housing; Change of partner; Altered sleeping arrangements; Alcohol or drug use on night in question. |

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## Situational & out of routine risks


- Key finding from both incident review and systematic literature review.
- SR found parents were often aware of safe sleep advice but did not act on it.
- Disrupted routines often led parents not to follow guidance (unable to or considered not relevant)
- Parents often 'cherry-pick' which safer sleep info to implement – viewed occasional risky scenarios as acceptable.
- "Models of intervention that rely solely on giving information are unlikely to produce meaningful change in this group" (Pease et al 2020).

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## Review recommendations

- Parents need advice from someone they trust and believe
- Providing parents with plausible mechanisms of harm (e.g. risk of suffocation when co-sleeping on a sofa) improves trust in safer sleep messages
- Planning for infant safety during disrupted routines might avoid rare but lethal scenarios.
- A differentiated approach to the delivery of safer sleep advice and information is essential where there are pre-disposing risks and other vulnerabilities.
- Design future preventative work with full participation of parents, partners, peers and wider family members.

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## Improving engagement

- Tailor safe sleep conversations to families' experiences and circumstances to make information more relevant and acceptable
- Take a 'whole family' approach rather than focussing solely on the mother or primary carer
- Offer plausible explanations so parents understand the nature of the risk
- Sense-check parents' instincts and beliefs about their infant's safety
- Be responsive to the reality of people's lives, don't dismiss their reality
- Develop deeper, more open relationships with families to improve safety
- Incorporate work on safer sleep into local strategies for responding to neglect, parental mental health concerns, domestic abuse and substance misuse
- Build awareness of safer sleep in crisis teams, shelter staff, emergency services

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## "What if…?" questions

Asking 'what if' questions can help parents with planning ahead. Feel free to make up scenarios relevant to the families you are working with!

Ask what would happen if…

Your new boyfriend came and stayed the night?
Some friends came round with a lot of alcohol?
One of your other kids was ill?

You had a visitor who was a smoker?
Someone brought you cannabis or other drugs?
You went to stay at a friend's place for the night?

You didn't feel safe here and needed to take the baby and leave?

Brainstorm scenarios with parents, peers, families and generate safe sleep options

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## Parental Mental Health

Many widely prescribed mood stabilisers can induce fatigue and sedation. Fatigued or sedated parents may lack motivation regarding infant sleep safety

This can be reduced via a 'whole family approach' -- ensuring the presence of another adult who takes responsibility for infant sleep safety and helps with night-time feeding and infant care (make this part of prenatal planning)

SUDI is associated with parental mental health disorders, but usually in combination with multiple other risk factors such as smoking, substance use, alcohol use, domestic violence etc.

When parent/s are unable to prioritise baby's needs or safety: need **Eyes on the Baby!**

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## Summary

- SUDI prevention interventions are now becoming specialised
- Maintain education and informed choice for universal provision
- Additional tools and interventions for families with additional needs
- Be especially mindful of children at risk – babies' needs not prioritised
- Uptake of universal provision can be enhanced by providing realistic explanations, prioritising key messages, delivering in multiple formats
- Discussion tools and 'What if' scenarios help support families with additional needs.
- Follow-up referrals from MAW who have opportunity for **Eyes on the Baby**
- Families where children are at risk need prolonged and specialised support especially when out of routine and unexpected things happen – help them plan ahead, emphasise baby's safety, advocate on their behalf.

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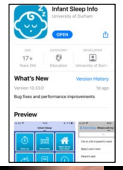
## Useful tools

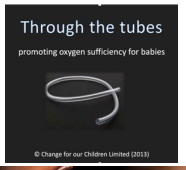
Infant Sleep App (Durham Uni)

**Bed-sharing decision tool**




Through the Tubes (Change for our Children, NZ)

**Airway protection teaching tool**

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## Resources

Please see the 'Resources' section of this learning platform for materials to download and links to online resources

Links to online leaflets/info
Links to useful tools
Downloadable Safer Sleep Checklist and Decision Tree

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## Implement & evaluate please!


Want to be an Eyes on the Baby Champion for your team?
Let us know!
Email infancy.sleep.centre@dur.ac.uk

To know whether this project makes a difference we need to hear your views…

Please respond!!

- Complete the training evaluation survey on this learning platform
- Implement the training in your work
- Complete the implementation surveys when we contact you
- Let us know how and when you use this info with new parents you come across.

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