Surrey Child Death Review Partnership

Safer Sleep Re-audit

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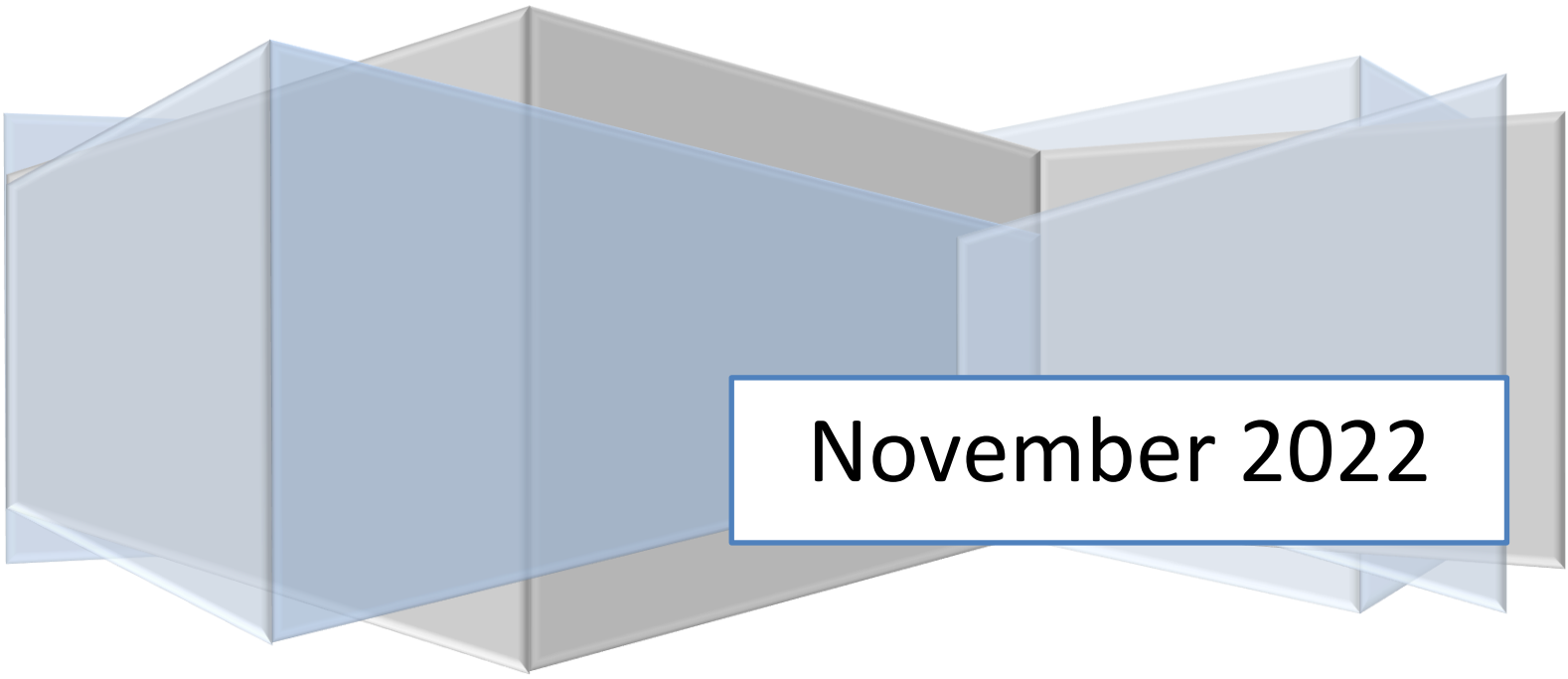


November 2022

Contents

Acknowledgments 2
Introduction: 2
Background: 3
AUDIT ONE(2016) 4
AUDIT TWO (2017) 5
Objectives: 6
AUDIT THREE (2022) ..... **Error! Bookmark not defined.**
Audit results: 8
Discussion: 15
Conclusions: 16
Recommendations: 17
Appendix 1: Safe sleep assessment contained in PCHR/Red Book 18

Acknowledgments

Thanks must go to colleagues in the Child Death Review Team for their tireless support with interviewing parents for this audit. Also, thanks to the community providers across Surrey for letting us attend their clinics to interview parents for this audit. Whilst we weren't at the clinics to review practice, there were so many examples of skilled professionals working tirelessly to support new families in Surrey, using their expertise and knowledge and we hope that the results of this audit will highlight the importance of early conversations with families around safer sleep.

Introduction:

1. In 2020, there were 150 unexplained infant deaths in England and Wales, which accounted for 6.7% of all infant deaths that year. This is a decrease from 2019 (187 deaths) and 2018 (213 deaths) We also see a declining trend for the total number of all infant deaths in England and Wales.

2. The unexplained infant mortality rate is a better measure for monitoring change over time than the actual number of unexplained deaths. This is because rates account for the number of live births each year.

3. The unexplained infant mortality rate has generally decreased since 2004. From 2014 to 2019 the rate remained stable at around 0.30 per 1,000 live births. The unexplained infant mortality rate in 2020 (0.24 deaths per 1,000 live births) is lower than previous years, although this provisional figure may be influenced by delays to death registrations because of the coronavirus (COVID-19) pandemic. ONS will continue to monitor these rates to assess if the downward trend continues.

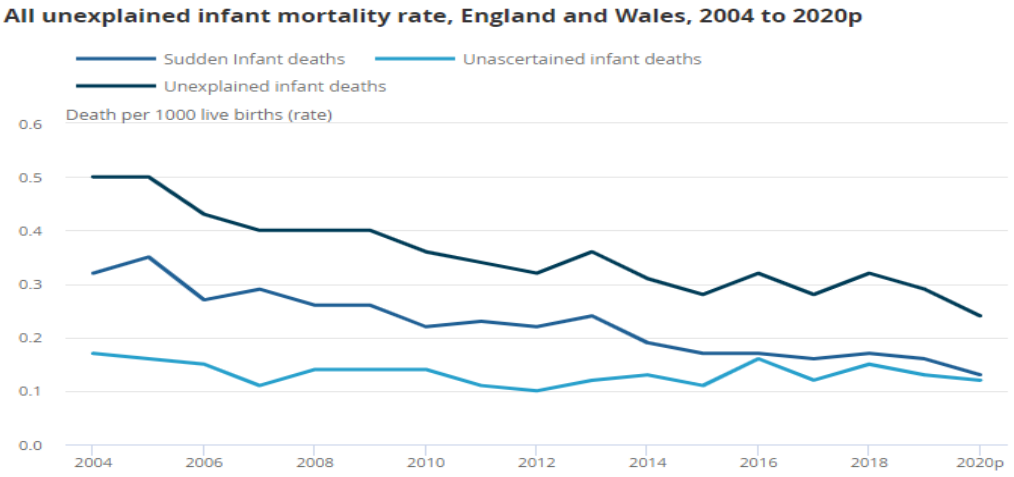


Chart 1: Office of National Statistics chart of all unexplained infant mortality rate, England and Wales 2004-2020.

4. The cause of Sudden Unexplained Infant Death (SUDI) is not known. It is possible that many factors contribute but some are known to make SUDI more likely. Risk factors for unexplained infant deaths include the baby's sex, birth weight, maternal age and socio-economic classification. Other risk factors include sleeping position, sleep environments, including bed-sharing where other risk factors are present, sleeping with a baby on a sofa, not breastfeeding, temperature and exposure to second hand tobacco smoke.
5. The National Institute for Health and Care Excellence (NICE) updated its quality statement on Safer Practices for Bedsharing in September 2022.[1] The statement recommends that 'Parents are given advice about safer practices for bed sharing at each routine postnatal contact.' With a rationale of 'Parents sharing a bed with their baby is common practice but there is often confusion and mixed messages about it. Giving parents advice at each routine postnatal contact about safer practices for bed sharing and when bed sharing is strongly advised against (such as avoiding certain sleeping positions or places, or after consuming drugs or alcohol), will support them to establish safer infant sleeping habits.'

Background:

6. Under the Children Act 2004, as amended by the Children and Social Work Act 2017, the two child death review partners (local authorities and clinical commissioning groups-now known as Integrated Care Boards) must set up child death review arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area. In accordance with the statutory guidance Working Together to Safeguard Children (2018) Child death review partners must make arrangements for the analysis of information from all deaths reviewed. The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they must inform them.
7. In 2014, a county wide Safe Sleep campaign was undertaken to raise awareness amongst professionals and parents of the risk factors that have been identified that increase the risk of infant deaths.
8. The final action of this campaign was completed in November 2014 with the inclusion of easily accessible Safe Sleep information for parents and a Midwife assessment in the Parent Child Health record (PCHR/Red book) to be completed with the parents as soon as possible after birth but by the latest, five days old. These pages were developed with the input and agreement of the Maternity services, 0-19 community services, Safeguarding Children and Public Health. NHS Guildford and Waverley CCG provided the funding for these pages in all PCHR/Red books across Surrey and Surrey Heartlands ICB have continued with the funding of these pages.

[1] Quality statement 5: Safer practices for bed sharing | Postnatal care | Quality standards | NICE

AUDIT ONE (2016)

In January/February 2016, a safe sleep audit was undertaken. The purpose of this audit was to measure:

- Completion, effectiveness and quality of the Safe Sleep Assessment
- Identify good practice
- Identify areas for improvement
- To provide assurance that the lessons learnt from Child Death Reviews are embedded in practice to protect other children and prevent future deaths

The recommendations identified from this audit were as follows:

- Consideration to be given by Acute and Community providers to have a consistent approach across the health economy with regard to standards for distributing PCHR/Red books to parents to ensure that the PCHR/Red books are always available to the Midwives. Midwife access to the PCHR/Red books is crucial for completeness of both the Safe Sleep assessment and birth details/new born examination in order to achieve compliance with the SSCP bruising protocol if invoked.

- Midwives to complete Safe Sleep assessment with all parents as soon as possible after the birth and by the latest, Day 5 as outlined in the assessment contained within the PCHR/Red book.

- Midwives to improve the quality of their recording of the Safe Sleep assessment with parents before the baby is 5 days old by ensuring the assessment is completed in full.

- When risk factors are identified during the Safe Sleep assessment, a discussion needs to take place with the parent/s of the action they will need to take in order to reduce these risks and this advice should be recorded on the action plan.

- Each health provider clinical lead to coordinate and report back in a timely way to their organisation on the outcomes of this audit and then agree a plan, for monitoring internally, in response to the findings. Agreement to be reached on timescales for completion of the recommendations by providers and quality assurance of action plans to be undertaken via SSCP Health and Safeguarding Sub Group.

- A re-audit to take place in January / February 2017

AUDIT TWO (2017)

A second audit was repeated in 2017.

The recommendations identified from this audit were as follows:

NICE quality statement 4: Infant health – safer infant sleeping states **"Women, their partner or the main carer are given information on the association between co-sleeping and sudden infant death syndrome (SIDS) at each postnatal contact."**[2]

- Commissioners to ensure that they commission services that provide information about the association between co sleeping and SIDS, and that trained healthcare professionals understand and explain this information and provide it to women, their partners or the main carers of babies at every postnatal contact

- Service providers to ensure that information about the association between co sleeping and SIDS is available and that healthcare professionals are trained to understand and explain the information and to give it to women, their partners or the main carers of babies at every postnatal contact.

- Healthcare practitioners to ensure that they understand and can explain information about the association between co sleeping and SIDS, and that they give this information to women, their partners or the main carers of babies at every postnatal contact.

- Consideration to be given by Acute and Community providers in Surrey to establish a consistent approach across the health economy with regard to standards for distributing Red books to parents to ensure that the Red books are always available to the Midwives. Midwife access to the Red books is crucial for completeness of both the Safe Sleep assessment and birth details/new born examination in compliance with the bruising protocol where relevant.

- Midwives to complete Safe Sleep assessment with all parents as soon as possible after the birth and by the latest, Day 5 as outlined in the assessment contained within the Red book

- Midwives to improve the quality of their recording of the Safe Sleep assessment with parents before the baby is 5 days old by ensuring the assessment is completed in full.

- During the Safe Sleep assessment, a discussion needs to take place with all parent/s regarding risk factors and the evidence base for the advice given. When risk factors are identified a further discussion needs to take place with the parents/s regarding

[2] https://www.nice.org.uk/guidance/qs37/chapter/Quality-statement-4-Infant-health-safer-infant-sleeping

the action they will need to take in order to reduce these risks and this advice should be recorded on the action plan.

- Each health provider clinical lead to coordinate and report back in a timely way to their organisation on the outcomes of this audit and then agree a plan in response to the findings. Agreement to be reached on timescales for completion of the recommendations by providers and quality assurance of action plans to be undertaken via SSCP Health and Safeguarding Subgroup.

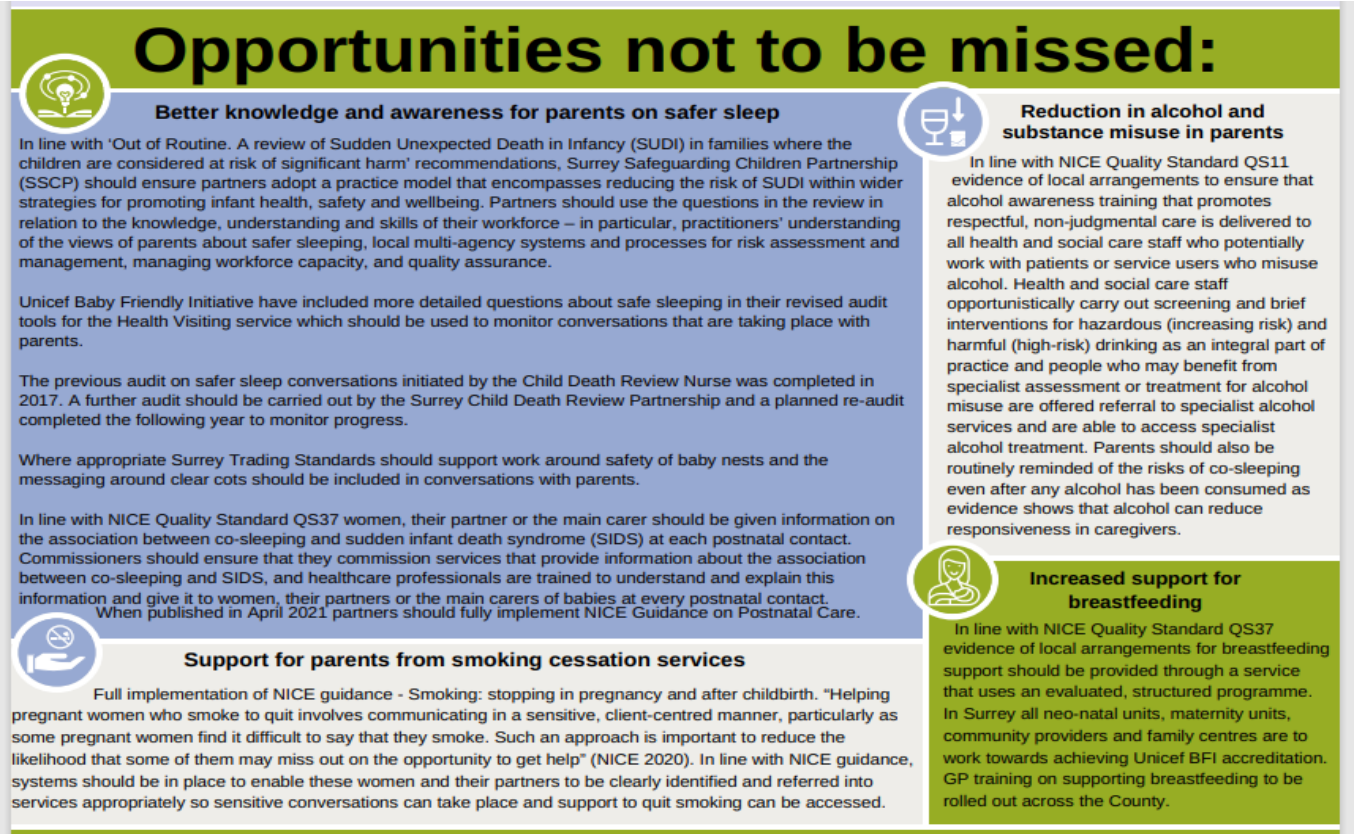
Audit 3 (2022):

The purpose of this third audit was to measure:

- Completion, effectiveness and quality of the Safe Sleep Assessment
- Identify good practice and any improvements in practice since the initial audit
- Identify further areas for improvement
- To provide assurance that the lessons learnt from Child Death Reviews in relation to Co-sleeping and risk factors are embedded in practice rather than implemented in the short term, in order to protect other children and prevent future deaths.

The audit was a recommendation of the '**SUDI in Surrey, a thematic review 2014 – 2020'**[3] which identified that between 1st April 2014 and 31st March 2020, 20 babies met the case definition for the thematic review of probable SUDI. 12 of the babies were female (60%) and 8 male (40%).

[3] Child-Death-Review-Partnership-SUDI-thematic-review-002-1.pdf (surreyscp.org.uk)



Methodology:

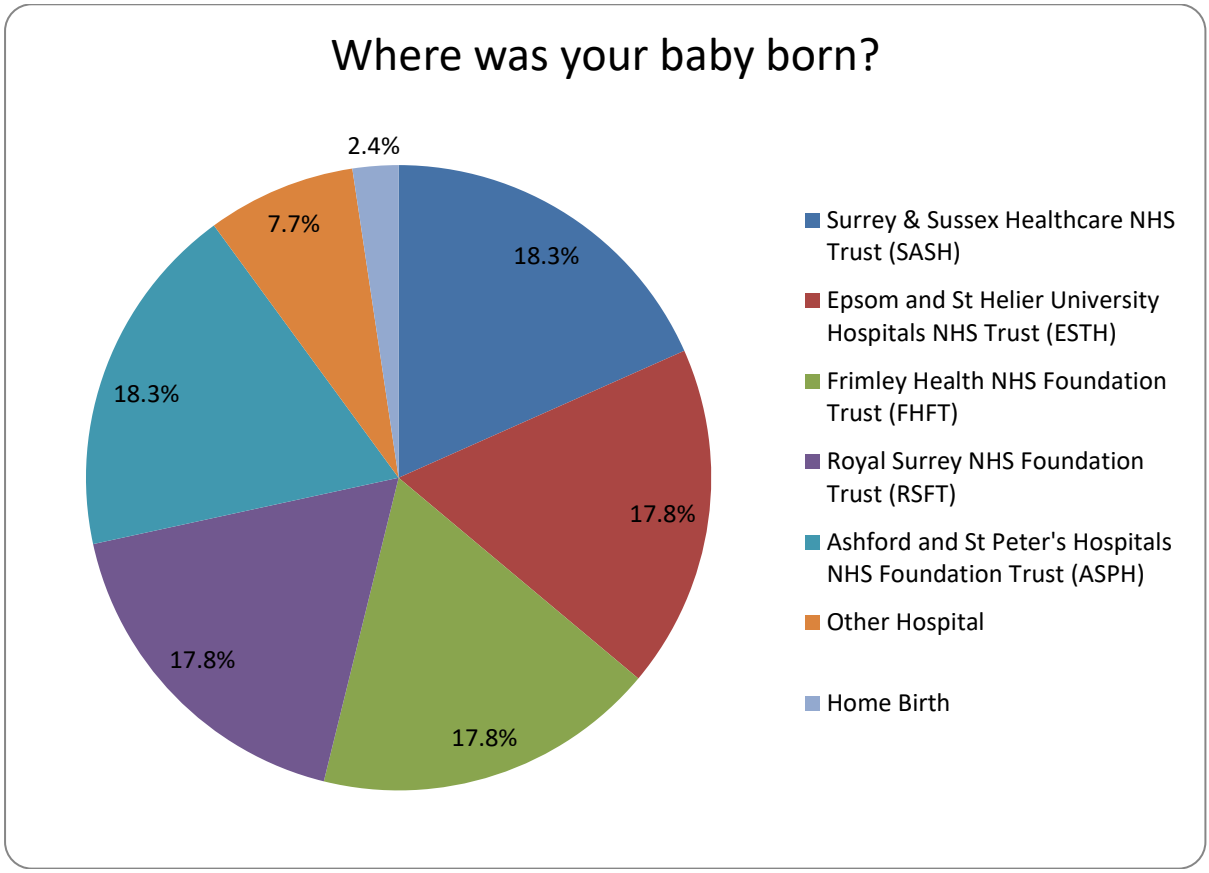
9. The Child Death Review team attended Child Health Clinics within the catchment area of each of the 5 Acute Hospitals across Surrey over a six month period April – October 2022. At each clinic setting, the parent/s were approached and asked to contribute to the audit by allowing a review of the Safe Sleep Assessment contained within their PCHR/Red book and a discussion on their understanding of safe sleep advice. The audit tool and the reason for auditing were explained to each parent and their consent to participate was sought.

10. This report will discuss the results of the audit and identify areas for improvement. The questions from the audit form are used for clarity when discussing the results.

Audit results:

Question 1: Where was the baby born?

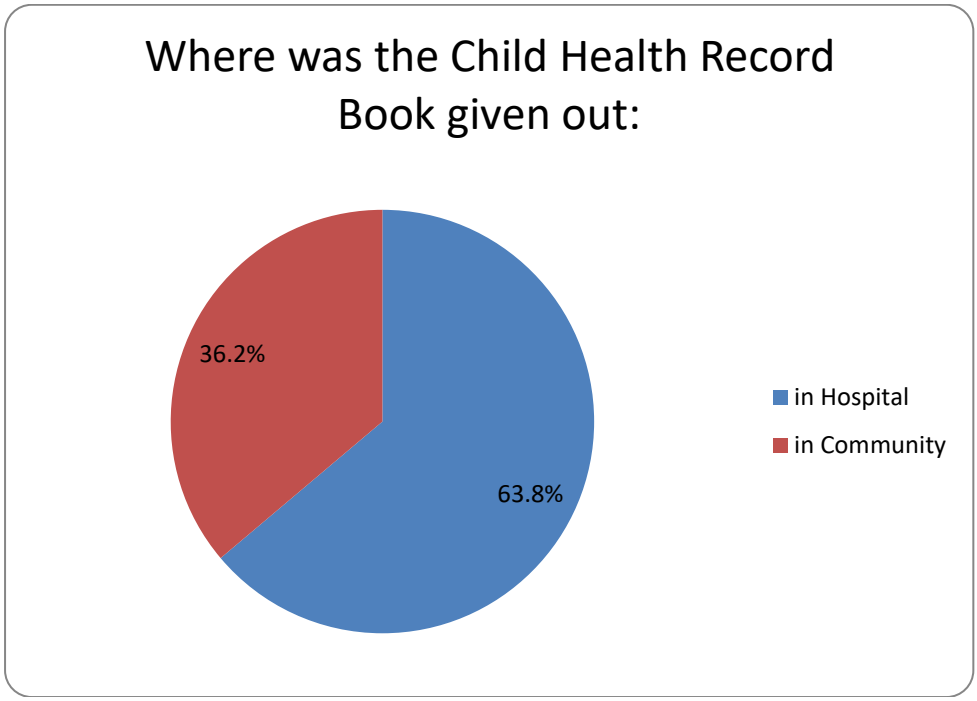
A total of 180 babies were included in the audit with 30 babies identified from each of the 5 Acute settings in Surrey i.e. Ashford & St Peter's Hospitals NHS Foundation Trust (ASPH), Frimley Health NHS Foundation Trust (FHFT), Royal Surrey NHS Foundation Trust (RSFT), Epsom and St Helier University Hospitals NHS Trust (ESTH) and Surrey & Sussex Healthcare NHS Trust (SASH) and other babies were either out of area or home births.



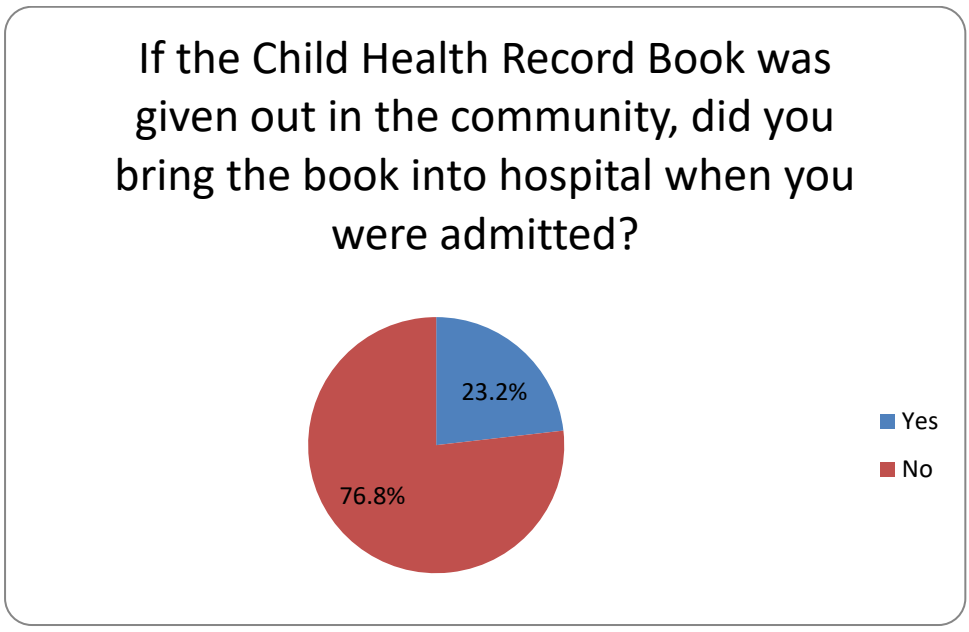
Question 2: Baby's Date of Birth:

The age range of the babies included in the audit varied from 4 weeks old to 12 months old.

Question 3: Was the Parent Child Health Record Book (PCHR/Red Book) distributed in the Hospital or the Community?

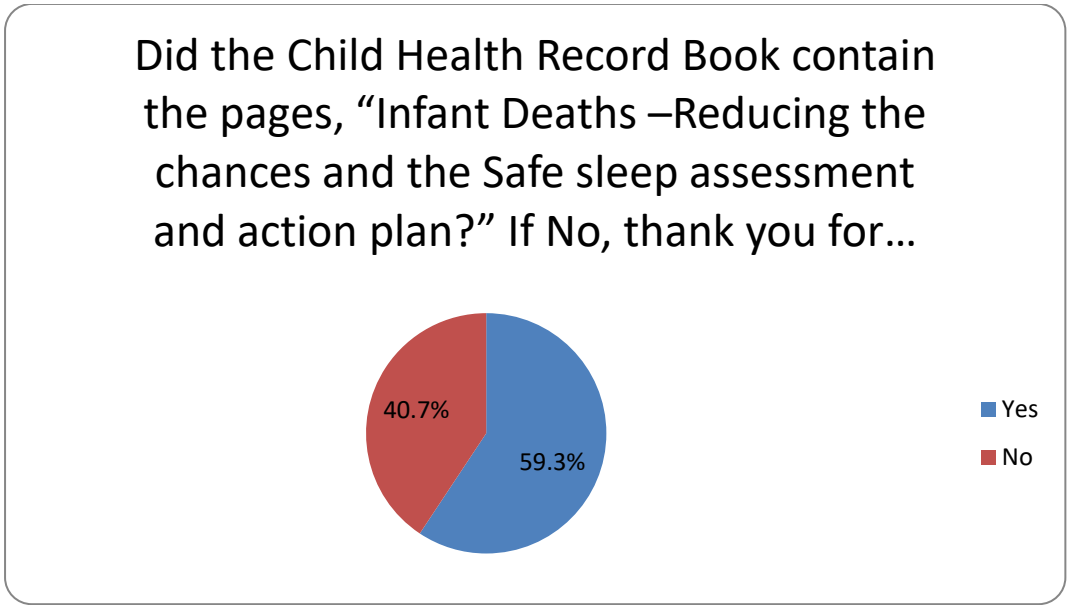


This compares with 50% in hospital and 50% in the community in 2017.



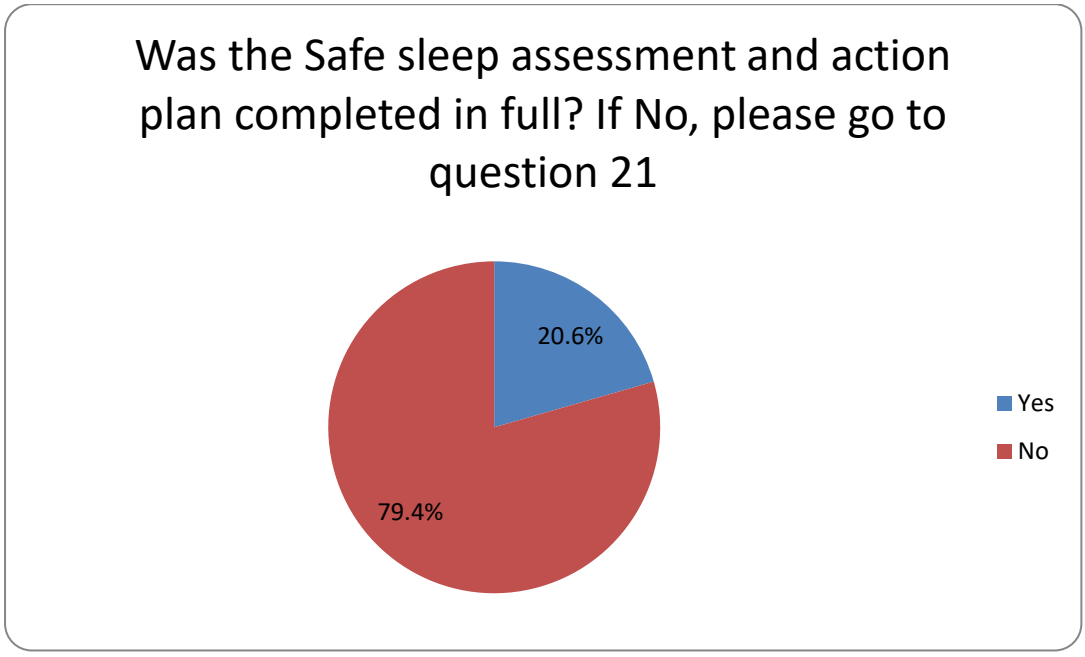
In the previous audit it was identified that the maternity units at ESTH and SASH did not have access to the PCHR/Red books. This was highlighted in the initial audit undertaken in February 2016 and there was no evidence in this audit that a resolution has been achieved by 2017 and again in 2022 a number of books weren't distributed in SASH. As a result some mothers did not receive their PCHR/Red books until day 10 when the Health Visitor met with the family.

Question 5: Did the PCHR (Red Book) contain the pages, "Infant Deaths – Reducing the chances and the Safe sleep assessment and action plan"?



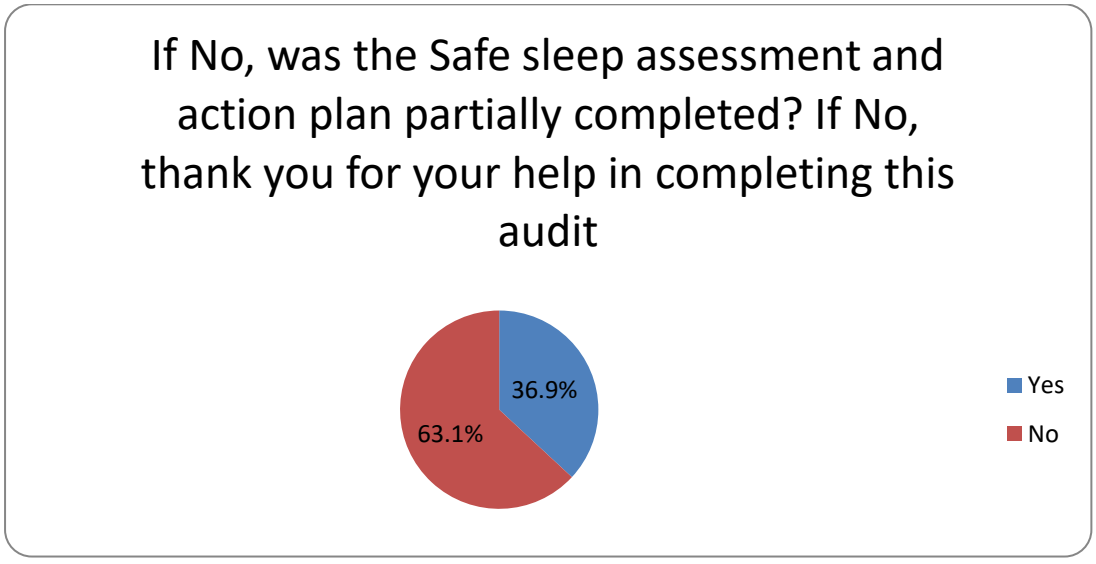
Of the red books examined, 40.7% did not contain the correct pages, this was 72 books in total, this is disappointing since in 2017 of the 50 PCHR/Red books included in the audit, 100% (50) included the Safe Sleep pages.

Question 6: was the safe sleep assessment and action plan completed in full?



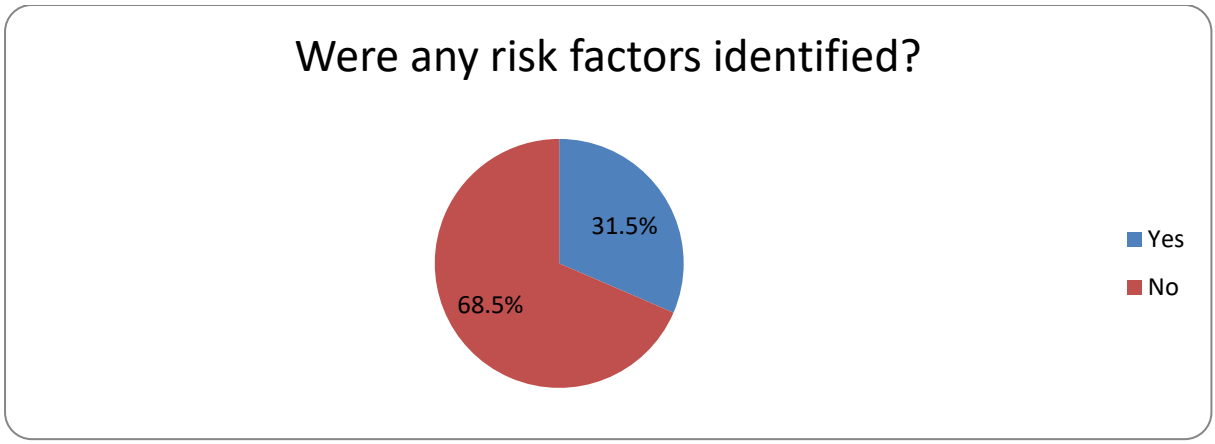
Of the 107 books that had a sleep assessment, only 22 (20.6%) had a sleep assessment fully completed which included the child's personal details, name, designation and signature of Midwife, date of assessment and the parents' name whom the assessment was completed with.
This is much lower than the 2017 and 2016 audit where the numbers had been 50% (18) and 52% (16) respectively.

Question 14 -19: Was the Safe sleep assessment and action plan (page 4b) partially completed?

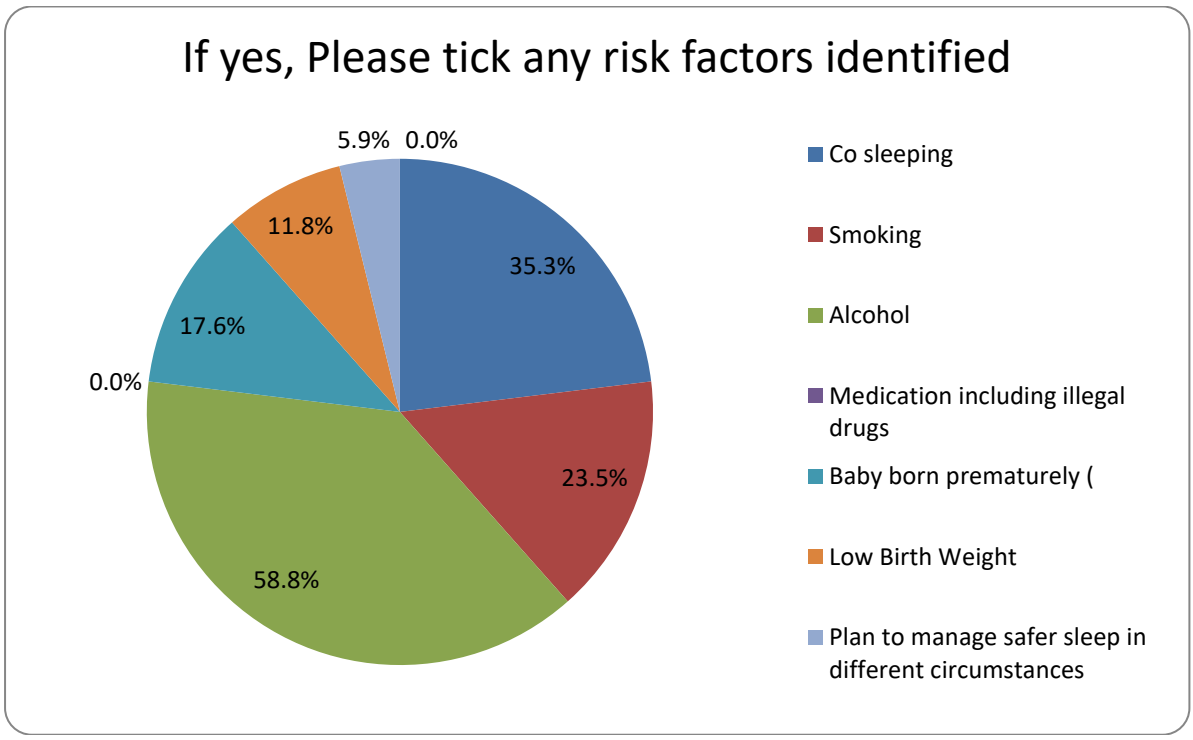


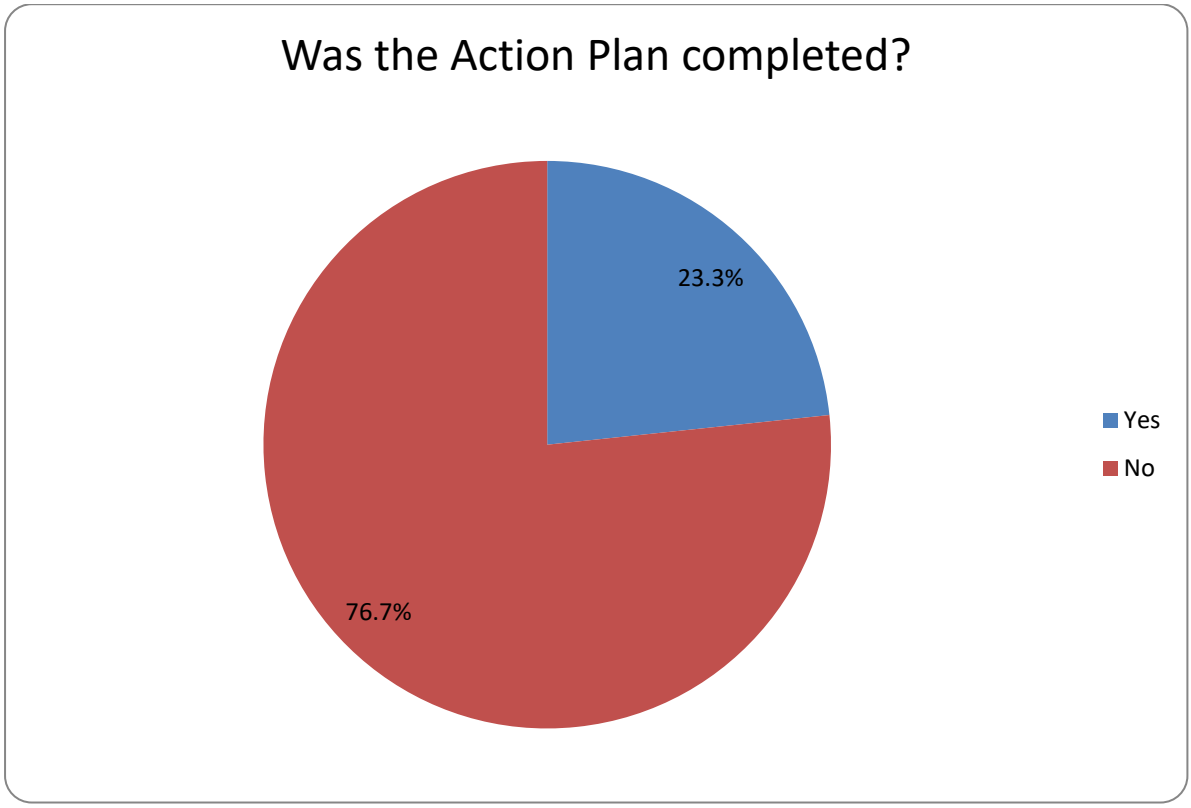
36.9% (31) of the books were partially completed, this compares favourably with 2017 where 14% (5) PCHR/Red books were partially completed.
36% (13) of the PCHR/Red books that were available were not completed at all which is a deterioration from the initial audit in 2016 where the previous number had been 22% (7).

Question 20-22: Were any risk factors identified and was the Action Plan completed if appropriate?



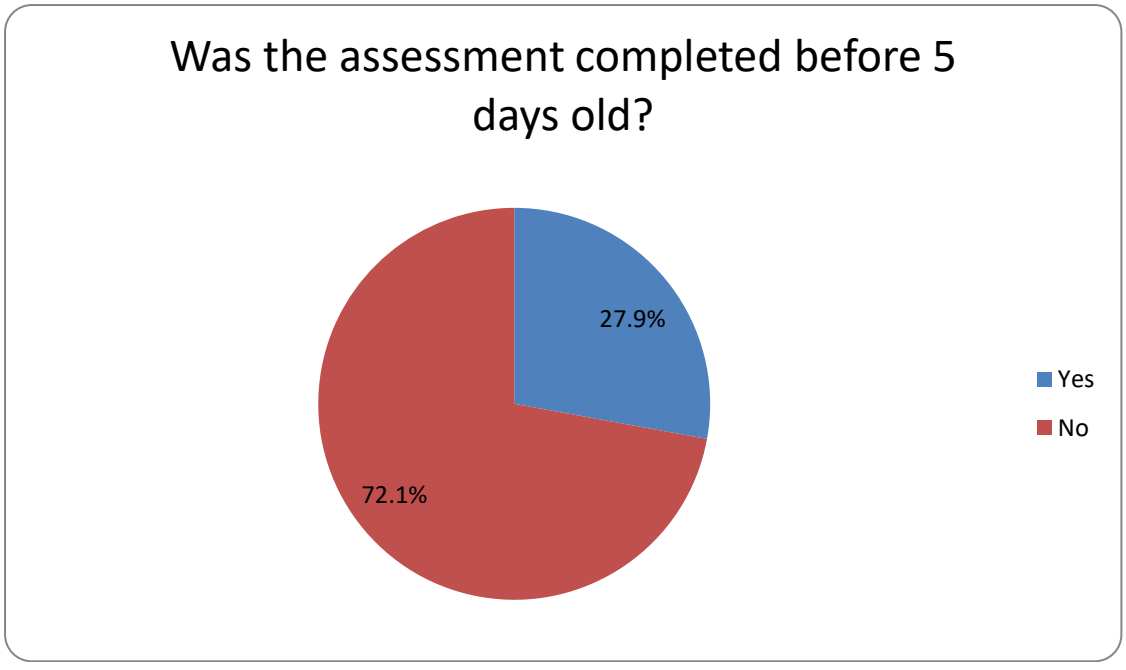
31.5% (17) of the fully/partially completed assessments identified risk factors, this remains static from the 2017 audit where 17% (4/23) of the fully completed/partially completed assessments identified risk factors and marks a decrease from the 2016 audit where 21% (5/24) identified risk factors.
Of the risk factors identified, the highest percentage (10 babies) related to alcohol.





Of those who had the assessment partially or fully completed, 14 had the action plan completed, this highlights an improvement compared with 1 in 2017 and 4 in 2016.

Question 23: Was the assessment completed by 5 days old?



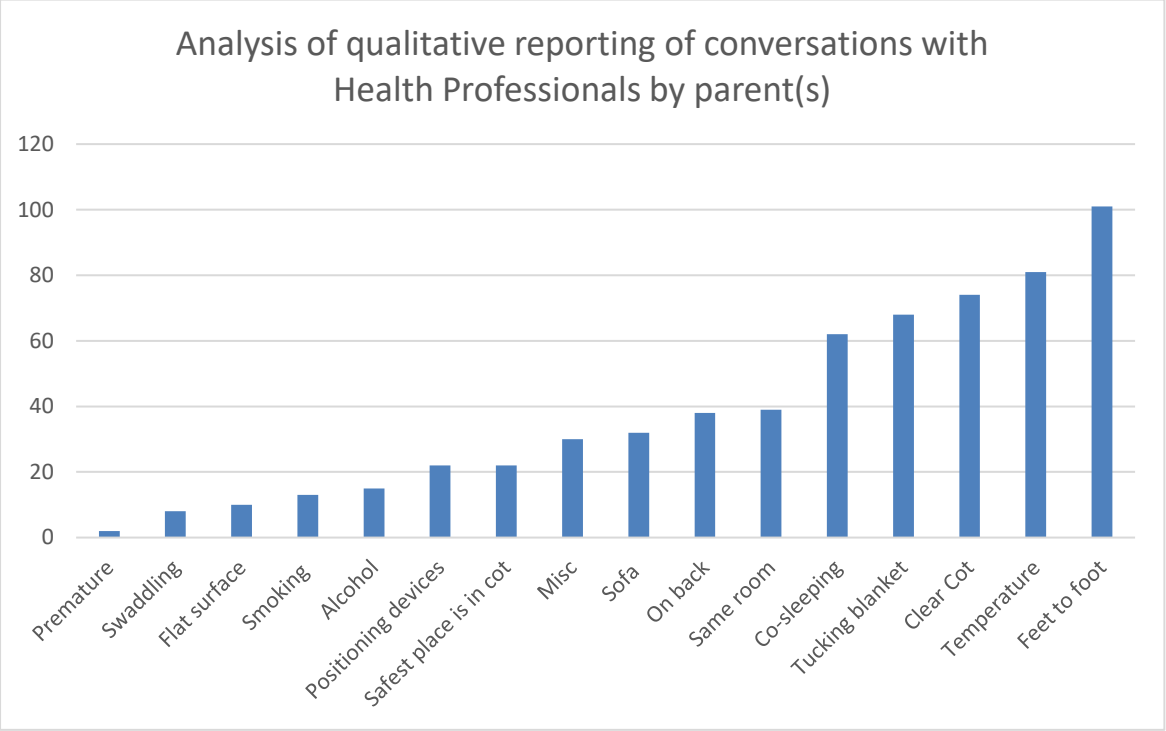
Of the assessments completed 27.9% (17/61) were completed by day 5, this highlights a marked decrease in comparison to 91% (21/23) in 2017 and 79% (19/24) in 2016

Questions to Parents at the end of audit:

Do you remember the conversation with your Midwife regarding Safe sleep?

Almost 92% (157/171) reported 'Yes' they remembered the conversation regarding safe sleep, this marks an improvement when compared to 67% (34/50) in 2017 and is similar to the audit in 2016 which was 96% (48/50).

Of the parents questioned about the conversations with Health Professionals, the main topics recalled are shown in the chart below:



It is interesting to note that the modifiable factors identified in our Surrey SUDIs are least likely to be recalled by parents.

Discussion:

11. The first and second audits identified that both ESTH and SASH did not have access to PCHR/Red books as these were given out in the community by the Health Visitors. This audit identified no evidence of change to this situation despite the recommendation that consideration be given by Acute and Community providers to have a consistent approach across the health economy with regard to standards for distributing PCHR/Red books to parents to ensure that the PCHR/Red books are always available to the Midwives.

12. The NICE guidance[1] states **1.2.3: "The personal child health record should be given to all women as soon as possible (if it has not been received antenatally) and its use explained."**

13. With regard to professional communication, the NICE guidance[1] also states that **1.1.9: "Healthcare professionals should use hand-held maternity records, the postnatal care plans and personal child health records, to promote communication with women"** [4]

[4] https://www.nice.org.uk/guidance/cg37

14. As previously highlighted in the previous audits, lack of access to the PCHR/Red books not only impacts on the Midwife's ability to complete the Safe Sleep assessment but also results in non-compliance with the bruising protocol if relevant. The SSCP multi agency protocol for the Management of Actual or Suspected bruising in Infants who are Not Independently Mobile states that accurate details of bruising from birth trauma and medical causes must be recorded in the personal child health record (PCHR/Red book) as well as in other health records. Lack of access to the PCHR/Red book for the midwife, increases the risk of false positive safeguarding referrals being made in the community as per bruising protocol and the resultant negative impact this can potentially have on families causing distress through unnecessary investigation and scrutiny.[5]

15. From the discussions, it was evident that the Back to Sleep advice is well embedded and the parents were able to recall it easily. The advice regarding co-sleeping and the associated risk factors appeared to be less so and the potentially modifiable factors identified from the SUDI thematic review seem to be rarely recalled by parents.

Conclusions:

16. It is disappointing that this re-audit highlights that the completion of the safe sleep assessment is not yet embedded in practice on a county wide level. On an individual level, there were examples of where the safe sleep assessment was embedded in practice.

17. The Safe Sleep assessment contained within the PCHR/Red book is a thorough assessment designed to be completed by the Midwife with the parent as soon as possible after the birth and by Day 5 at the latest. The inclusion of the assessment in the Red book also allows parents easy access to the advice regarding Safe Sleep and this advice can be revisited regularly throughout the first year of life as recommended by NICE. Only 30% of assessments were completed by day 5.

18. On discussion, mothers reported the assessment to be thorough and they valued it being completed as it helped to highlight the importance of safe sleep at a time when they felt they were receiving a lot of other information.

19. It is only through consistent and regular discussions with parents about safer sleep that Health Professionals can empower parents to change behaviour and adopt safe sleep practices in order to protect children and prevent future deaths.

[5] http://surreyscb.procedures.org.uk/hkpzh/procedures-for-specific-circumstances/a-multi-agency-protocol-for-the-management-of-actual-or-suspected-bruising-in-infants-who-are-not-independently-mobile

Recommendations:

20. Full implementation of the SUDI thematic review recommendations on completion of the red book before day 5 is essential if we are to ensure that these conversations are taking place with parents and are documented.

21. There should be signposting to evidence-based advice and clear conversations on the modifiable factors which increase the risk of SUDI.

Appendix 1: Safe sleep assessment contained in PCHR/Red Book

Safe sleeping assessment and action plan

(to be completed by a midwife before 5 days or at first opportunity on arrival home)

Have you discussed and observed safe sleeping environments?

- In own cot, in parent's room for first 6 months: Yes ☐ No ☐
- Sleep on back/feet to foot: Yes ☐ No ☐
- Room temperature/suitable bedding/clothing/toys: Yes ☐ No ☐
- Day time sleep: Yes ☐ No ☐
- Sofas/ chairs/ car seats/ beanbags/ slings: Yes ☐ No ☐
- Tiredness/ accidental falling asleep in bed/ couch/ chair when feeding/cuddling: Yes ☐ No ☐

Risk Factors

Do you ever share your bed with anyone else, including other children/pets?
Yes ☐ No ☐

Did you smoke at any time during your pregnancy?
Yes ☐ No ☐

Do you or anyone in the house smoke, including visitors?
Yes ☐ No ☐

Do you or your partner drink any alcohol?
Yes ☐ No ☐

Do you or your partner ever take any medication that might make you sleepy, including illegal drugs?
Yes ☐ No ☐

Was your baby born prematurely (before 37 weeks) or low birth weight (less than 2.5kgs)?
Yes ☐ No ☐

Surname:
First name:
DOB:
NHS No
Address:

Do you have a plan to manage safe sleep for your baby in different circumstances e.g. sleeping away from home, after drinking alcohol, baby unwell?
Yes ☐ No ☐

Have you or any close family member ever suffered the sudden death of a baby? Yes ☐ No ☐

Action Plan

.....

.....

.....

Completed by: ..... (print name)

Designation: .....

Signature: ..... Date: .....

Completed with: .....

Relationship to child .....

Signature: ..... Date: .....

Safe sleeping assessment and action plan

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Infant deaths - reducing the chances

www.isisonline.org.uk 'Caring for your baby at night: a guide for parents
www.unicef.org.uk/babyfriendly/resources/resources-for-parents/caring-for-your-baby-at-night/

The safest place for your baby to sleep is on his/ her back in a cot in a room with you for the first six months.

* Place your baby with their feet to the foot of the cot, to prevent them wriggling down under the covers.
* Do not let your baby become too hot, and keep your baby's head uncovered indoors
* Do not place your baby on his/ her tummy or side to sleep.
* Never sleep on a sofa or armchair with your baby or leave your baby to sleep on the sofa.
* Do not smoke in pregnancy – fathers too! Do not let anyone smoke in the same room as your baby
* Breastfeeding your baby reduces the risk of cot death
* Don't forget, accidents can happen: you might roll over in your sleep and suffocate your baby, or your baby could get caught between the wall and the bed, or baby could roll out of an adult bed and be injured
* If your baby is unwell seek medical advice promptly
* Bed sharing is never recommended for premature babies.
* Do not keep a hat on your baby in the house or leave his/her outdoor clothing on when returning home from an outing, even if it means you wake your baby.

It's especially dangerous for your baby to sleep in your bed if you (or your partner)

* are a smoker, even if you never smoke in bed or at home
* have been drinking alcohol
* taken medication or drugs that make you drowsy
* are bottle feeding
* are overweight

Or if your baby:

* was born before 37 weeks
* weighed less than 2.5kg (5½lbs) at birth

Smoke Free Zone. Do not smoke anywhere near your baby

Infant deaths - reducing the chances

3d