Derby and Derbyshire Safeguarding Children Partnership

NHS Derby and Derbyshire Clinical Commissioning Group

Three Steps for Baby Safety

Partnership Strategy to Support the Safety of Babies in Derby and Derbyshire

Final February 2021: Authors - Juanita Murray and Kayleigh Noble: Chair and Vice Chair of the Derby and Derbyshire Keeping Babies Safe Steering Group

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Strategy to support Parents and Carers to keep their babies safe in Derby and Derbyshire

Safe Sleep **Safe Handling** **Safe Space**

Introduction

Babies are entirely dependent on their immediate care givers for all their needs and because of this they are vulnerable. A parent's capacity to respond appropriately to the emotions and needs of their baby has a profound impact on baby brain development and general health and wellbeing. All babies need to be safe, nurtured and able to thrive.

The early care they receive provides the foundations for all physical, social and emotional development. Whilst most parents do provide the love and care their babies need some parents find the transition into parenthood stressful and demanding and are vulnerable themselves. This can sometimes result in a baby suffering abuse and neglect. The identification and assessment of the vulnerability of families who have a baby to care for is essential to ensure that babies remain safe in Derby and Derbyshire.

Partnership Aim

Derby and Derbyshire Safeguarding Children Partnership (DDSCP) and the Child Death Overview Panel (CDOP) encourage and support partners in all agencies who care for or support families with babies under a year old to utilise this strategy and deliver the clear consistent messages regarding baby safety to families, **including all fathers** and wider family members, and to their colleagues within their own organisation.

All practitioners in Derby and Derbyshire should have access to research based practice and information to educate and support parents and carers so that they are able to make safe choices when caring for their baby.

The partnership aims to reduce the numbers of babies who die or are seriously injured following unsafe sleep practice, unsafe handling and those that die accidentally.

Partnership Objectives

- That all learning from national and local Child Practice Reviews and CDOP is disseminated and any recommendations to support and enhance the safety of babies are acted on by all partners

- To ensure that practitioners across Derby and Derbyshire have a good knowledge of safe sleep practice, the importance of safe handling and the advice around safe baby equipment and home safety messages

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- To ensure that there are consistent and clear messages regarding safe sleep practice delivered to all new parents and carers including fathers and wider family members if appropriate

- To ensure that safe handling and the programme 'Shaking the baby is just not the deal', is delivered to all mothers and fathers and/or carers before the baby leaves hospital or as soon as possible following the birth

- To ensure that parents and carers are aware of the importance of safe equipment and the safe use of car seats

- To ensure that parents and carers are aware and understand how to make their home 'baby safe' particularly regarding the use of nappy sacks and the dangers associated with blind cords

- That all practitioners across the partnership who have contact with families with babies feel confident to deliver the key messages

- To promote curiosity amongst practitioners regarding where a baby sleeps both day and night and to ask the question 'is this is a safe environment/space for your baby?'

Practitioners need to recognise that some families may have additional vulnerabilities and require extra support to understand the messages and to make the right choices for their baby's safety.

All practitioners who have contact with babies and their families should think about the Three Steps to Baby Safety.

Audience

All practitioners who have contact with pregnant women and children under 1 year of age, their families and carers including hospital and community staff, GP's, Children's Social Care, the Police and Early Years settings.

Practitioners and professionals who are aligned to the Safeguarding Children's Partnership

Practitioners and professionals who are aligned to the Child Death Overview Panel

Messages from Serious Case Reviews and Child Practice Reviews

Learning from Serious Case Reviews (NSPCC 2017)

The learning from the NSPCC highlights that professionals should work together to maintain a focus on the needs and experiences of very young children in vulnerable families.
The key messages are:-

- Vulnerable parents may need extra support
- Premature babies may be more vulnerable to abuse and neglect
- Professional optimism may lead to risks being underestimated
- Professionals need to engage with all adults in a baby's life

Learning for practice:

- Assessments should be child focused and prioritise the needs of the child
- Assessments should be ongoing so any new risk can be identified and responded to
- Pre-birth assessments should be completed in good time to allow for any intervention
- The voice of the child needs to be understood to form a clear picture of a baby's daily lived experience?
- Look beyond a baby's basic care needs and consider their emotional, psychological and/or therapeutic needs.

Check that parents understand and are continuing to follow safety advice and guidance, for example about safe sleeping, bathing or keeping infants away from potential hazards.

The Child Safeguarding Practice Review Panel Annual Report (DfE 2020)

This report is an analysis of 538 Rapid Reviews received by The Child Safeguarding Practice Review Panel and 126 Serious Case Reviews completed between July 2018 and December 2019.

The report highlighted the unacceptably high number of deaths of babies when co-sleeping in families where abuse and neglect is a factor. There were over 40 in a 16 month period.

27% of deaths or serious harm of children under 1 year reported in the Rapid Reviews were due to non-accidental injury. The perpetrators were overwhelmingly the child's parents or parental partners.

The overarching themes from the Rapid Reviews are;

- Risk assessment
- Information exchange/sharing
- Poor escalation of concerns
- Optimistic thinking

The vulnerabilities of families is a common theme including parental misuse of drugs and alcohol and parental mental health difficulties.

Two of the priorities for The Child Safeguarding Practice Review Panel in 2020 are:

- A review of sudden unexpected death of infants where abuse and neglect were an identifiable factor
- A review of non-accidental injury in babies under 1 year of age

The Child Safeguarding Practice Review Panel

Out of Routine: A Review of Sudden Unexpected Death in Infancy (SUDI) in families where the children are considered at risk of significant harm (DfE 2020)

'The sudden and unexpected death of an infant is one of the most devastating tragedies that could happen to any family. In spite of substantial reductions in the incidence of sudden unexpected death in infancy (SUDI) in the 1990s, at least 300 infants die suddenly and unexpectedly each year in England and Wales.'

(Data from NHS Digital: Child Death Reviews 2019)

The review examined 14 incidents of SUDI that are representative of the 40 cases that were notified to the National Child Safeguarding Practice Review Panel.

The review established that the risk factors for SUDI are well recognised, and the steps parents can take to reduce the risk have formed part of the clear, consistent and evidence-based safer sleep messages for years. However it is apparent that whilst the safer sleep messages may be rigorously delivered by health professionals, many of those families who are most at risk are either unwilling or unable to receive or act on those messages for many reasons.

The review found that in 38 out of the 40 deaths co sleeping was a factor. There were also common themes of alcohol and drug use and issues related to parental mental health.

Key Findings and Learning:

- Families in adverse circumstances: A range of known pre-disposing risk factors for SUDI were identified. These are families that are typically living within a background of vulnerability and risk and where disruption to what would be considered normal routines make it difficult to engage with standard safe sleep advice.
- The importance of partnership working and a flexible approach to delivering consistent messages regarding safe sleep taking into account families vulnerabilities and their ability to respond to situational risk and out of routine circumstances.
- Development of a 'prevent and protect' model that reflects the risks to babies in families which includes: - Robust commissioning to promote safer sleep, multi-agency action to address pre-disposing risks of SUDI, differentiated and responsive multi-agency

practice with families all of which should be underpinned by relevant policy, procedures and practice tools.

The report concludes that families with children at risk of significant harm through child abuse and neglect also face a number of other risks related to their backgrounds, context and circumstances.

'Situational risks and out-of-routine circumstances act together to increase the risk of SUDI and may mean that families find it difficult or impossible to engage with standard safer sleep messages.

We believe that practitioners in all agencies who are working with families with children at risk need to develop a clearer evidence-informed understanding of parental decision-making in relation to the sleep environment and how this might be changed. Such understanding backed up by a flexible, relationship-based approach to working, could improve the impact of safer sleep advice on all families, and particularly those with children considered to be at risk. ' (DfE 2020)

Derby and Derbyshire Case Reviews

Since 2015 there have been 13 case reviews (of different types including serious case reviews, local reviews and rapid reviews) where a baby has died or experienced serious harm as a result of abuse or neglect across Derby and Derbyshire.

All professionals and practitioners must recognise the vulnerability of babies during the first year of life. Where change and action is required by the parent of carer, the professional working with the family must be clear regarding what needs to change and how the impact of the change will be assessed. Important changes to a baby's care must be timely and checks put in place to ensure any positive changes are sustained. This includes urgent escalation to children's social care if there are concerns that progress is not being made or the baby is at risk of significant harm.

The risk of a baby suffering serious harm is significantly increased because of their development, vulnerability and total dependency on their care giver for their welfare and safety.

Domestic abuse, parental mental ill health, parental substance misuse and stressors occurring for the adults in the family are features apparent in many of the cases where harm has occurred. All professionals and practitioners should be alert to the circumstances of parents or carers and understand the risks to children within the family and may need to consult with other agencies to support their understanding of the impact on the adults and the lived experience of the child.

Learning from these reviews has highlighted some key areas for all professionals and practitioners to incorporate within good practice.

- Be very alert to indicators of poor development or potential harm to babies

- Consider the individual baby's lived experience and make sure that factors affecting the care of the baby are understood. Get professional advice where it is needed

- Make sure the role of all adults, including fathers where they are part of the family, is properly understood and any stress factors routinely explored with individual adults separately

- Make sure that other professionals involved with the family understand any concerns. This is an individual professional responsibility and underpins good information sharing

If there is any doubt in your mind get safeguarding advice or supervision. Don't stop raising your concern until you feel confident your concern has been addressed.

If you remain concerned please follow the DDSCP Dispute Resolution and Escalation Policy

https://www.proceduresonline.com/derbyshire/scbs/user_controlled_lcms_area/uploaded_files/Multi%20Agency%20Dispute%20Resolution%20&%20Escalation%20Policy%20Dec%202019%20Final.pdf

All professionals and practitioners have a duty to protect babies from abuse and neglect. The research and national reviews in this document would suggest that although we know all babies are vulnerable, some babies are more vulnerable to abuse and neglect depending on the vulnerability factors within families.

It is important that all professionals and practitioners seek advice if they are concerned about a baby or child and if they are concerned about significant harm make a referral to Children's Social Care.

There are information and tools available to all professionals and practitioners which are easily accessible.

Important Safeguarding Information to Remember:-

- 'If babies don't cruise they rarely bruise'. Any bruise seen on a pre mobile baby must result in an immediate child protection referral to Children's Social Care

  https://www.proceduresonline.com/derbyshire/scbs/user_controlled_lcms_area/uploaded_files/Practice%20Guidance%20on%20Bruising%20in%20Babies%20&%20Children%20Nov%202018%20FINAL.pdf

- Please use the Pre Birth Protocol and Assessment if there are any safeguarding concerns during pregnancy

  https://www.proceduresonline.com/derbyshire/scbs/user_controlled_lcms_area/uploaded_files/Derby%20and%20Derbyshire%20Pre%20Birth%20Protocol%20FINAL%20May%202020.pdf

- Remember to use the Safeguarding procedures, they are there to help you https://derbyshirescbs.proceduresonline.com/index.htm

  Any questions or queries regarding any safeguarding issue seek advice from the Named Safeguarding Leads in your organisation.

Safe Sleep

The Research

Since the launch of the Back to Sleep Campaign in England and Wales in 1991, the number of SIDS deaths has fallen by 82% (Lullaby Trust 2019).

The sudden and unexpected death of a baby is usually referred to by professionals as 'sudden unexpected death in infancy' (SUDI). The death of a baby that is unexpected is also sometimes referred to as 'sudden infant death'.

Some sudden and unexpected deaths can be explained by the post-mortem examination, revealing, for example, an unforeseen infection or metabolic disorder. Deaths that remain unexplained after the post-mortem are usually registered as 'sudden infant death syndrome' (SIDS).

SIDS is rare especially following the success of the 'Back to Sleep' campaign. The most recent data from the Office of National Statistics is up to 2017. There are approximately 200 unexplained deaths of babies each year. The percentage of babies under 1 year who die of SIDS each year is reducing. In 2017 in the UK 0.26% of 1000 live births died of SIDS.

SIDS in the UK (Babies under 12 months) (ONS 2017)

Year	England and Wales	UK Total	UK Rate per 1000 live births
2017	183	200	0.26
2016	226	247	0.32
2015	195	220	0.28
2014	217	235	0.30
2013	252	278	0.56

SIDS by Government Office region, 2017 England and Wales: (ONS 2017)

	North East	North West	Yorks Humber	East Mids	West Mids	East England	London	South East	South West	Wales
No	11	30	17	19	24	11	20	26	16	9
Rate	0.40	0.36	0.27	0.37	0.35	0.16	0.16	0.26	0.29	0.28

The East Midlands had the 2nd highest rate per 1000 deaths in 2017.

183 unexplained infant deaths occurred in England and Wales in 2017, a rate of 0.27 deaths per 1,000 live births a statistically significant decrease from 0.31 deaths per 1,000 live births in 2016.

- Just over half (55.2%) of all unexplained infant deaths were boys in 2017 (0.29 deaths per thousand live births). This is a slight increase of from 51.3% in 2016.

- The number of unexplained infant deaths has decreased for mothers of all age groups since 2004 but the smallest decline was for mothers aged under 20 years.

"The rate at which babies died from an unexplained cause before their first birthday fell to the lowest level on record in 2017 – almost halving since records began in 2004. The new low comes after our last set of figures showed an increase between 2015 and 2016, and re-establishes the long-term trend. The fall in unexplained deaths may be due to factors such as fewer expectant mothers smoking and more awareness of safer sleeping practices."

Office for National Statistics (2017)

Unsafe Sleep Practice

Saving Babies Lives – All Babies are Vulnerable

Although SIDS is now very rare, approximately 200 babies still die every year. The risk of babies dying from SIDS would be reduced if families followed the clear messages developed from research. It is important that all practitioners and professionals are delivering clear and consistent messages to support families to understand how to avoid the specific risks to their baby, by doing the number of babies dying from SIDS would be reduced.

There needs to be an assessment of vulnerability factors within a family and the messages need to be targeted towards the specific needs of some families taking into consideration the level of understanding, language and cultural considerations.

The key safe sleep messages need to be delivered to families consistently by all practitioners. All practitioners should take responsibilities for sharing these messages with families even if this is on more than one occasion.

Asking parents where and how babies sleep should be a routine enquiry by all practitioners who have contact with families where there is a baby under 1 year. Practitioners who visit the home should see where the baby sleeps both day and night.

Three Key messages from the Lullaby Trust that will make a difference

- **Put babies on their back for every sleep**
- **Babies should sleep in a clear flat sleep space**
- **Keep babies smoke free day and Night**

Back to Sleep

The significant drop in the number of SIDS deaths has been largely attributed to the success of the message to sleep babies on their back: never their front or their side.

'Despite this clear message being in place for many years, around 10% of families still do not adhere to the message, and sleep their baby in another position.'

(Lullaby Trust safer sleep saving babies lives)

Messages to remember

- Babies need to sleep on their backs for every sleep from day one. The research tells us even if a baby sleeps differently for the odd night the risk of SIDS peaks at this time
- Premature babies should sleep on their back when they go home even if this was not the case in hospital
- It is not safe for a baby to sleep on their side and they should never be propped into a sleep position. Babies with reflux or colic should not be placed on their front or side. If there are health concerns and families feel that sleep position is detrimental they should seek a medical opinion before changing the safe sleep position
- Babies may seem more settled and sleep longer on their tummy but longer deeper sleep is not safe sleep. The risk of SIDS is much higher for babies who sleep on their tummy
- It is important that all family members including grandparents are educated on safe sleep to ensure there is a think family approach to the message

Clear, Flat Sleep Space

All families circumstances are different. Practitioners need to discuss with families how they plan to achieve a clear, flat sleep space. Vulnerable families may need additional support. This should be planned before the baby arrives.

Messages to remember:

- Babies should sleep in the same room as their parent or carer (day and night) for the first six months. Check if this is possible, and advise for the next best alternative if it is not possible
- Babies need a firm, flat mattress with no raised or soft sides
- No pillows, quilts or duvets, bumpers
- No pods, nests or sleep positioners
- Make sure their baby's head is kept uncovered so they don't get too hot

- If the baby sleeps in a sling or baby carrier make sure parent are aware of the TICKS guidance for safe use

Smoke Free

It has been estimated that the number of babies dying of SIDS could be halved overnight if we eliminated smoking in pregnancy. Babies should not be exposed to smoking and in a smoke free environment both before and after birth

Messages to Remember:

- Discuss smoking with the family - this will have already been raised during pregnancy but sometimes families need support to help make the decision to quit and you might make all the difference
- Refer for specialist support – families do not need to tackle this alone
- Ask about smoking beyond the immediate family – what about visitors, other members of the family, do the parents feel able to tackle this or do they need support?
- Remember smoky places; are parents aware of keeping the baby smoke free at all times?

Support Breastfeeding

SIDS risk is halved in babies who are breastfed for at least 2 months (Lullaby Trust)

- In the antenatal period, discuss infant feeding and how to get breastfeeding off to a good start
- Let families know that breastmilk is all a baby needs for the first six months, and thereafter alongside other foods for two years and beyond
- Refer families to support networks to aid and support the continuance of breastfeeding including local feeding advisors and UNICEF UK
- **If the family is not high risk** (see risk assessment below) then parents should be supported to find a comfortable and safe position for mum to breastfeed her baby in whilst lying down in bed. This will allow mum to get more rest overnight which may allow her to continue breastfeeding for longer and provide ongoing protection for her baby in reducing the risk of SIDS (UNICEF UK)

  If Mums are not supported to do this they may choose to try and feed in a more dangerous position such as sitting up in bed or on a chair or sofa

Bed sharing

On any night 22% of baby's in England will be sleeping in bed sharing situations. (BASIS 2019)

Of the babies who died whilst sharing a bed with an adult, 90% died in hazardous co-sleeping situations. (Lullaby Trust) **Therefore, families should never fall asleep with their baby when:**

- They have drunk any alcohol
- They or their partner smoke
- They have taken any drugs that make them feel sleepy or affect their awareness, this includes all illegal drugs including cannabis and prescribed drugs where a side effect is drowsiness
- Their baby was born prematurely or the baby's birth weight is under 2.5kg or 5½ lbs
- Extreme tiredness of one of the parents (for example – less than 4 hours sleep in the last 24 hours)
- They or their baby are unwell or have a viral illness

Bed sharing needs to be discussed with families to ensure they are aware of the dangers if they fall asleep accidentally.

Babies can and do die in high risk bed sharing situations. When talking to parents the Lullaby Trust found that if parents are told not to bed share with no explanation they will then feel they cannot discuss the issue and will not seek the correct safety advice.

All families should be told they should never fall asleep with their baby on a sofa or chair

Safe Sleep Risk Assessment
All families need to be risk assessed and know how to assess their own situation for bed sharing as the information from Serious Case Reviews/Child Practice Reviews and CDOP informs us that bed sharing is something parents do with their babies and don't always share this information with practitioners. Some families will be at high risk if parents decided to share their bed with their baby. This would include many vulnerable families.

These families need to be informed why they are at high risk and therefore why bed sharing is not advised.

HIGH RISK OF SIDS – DO NOT BED SHARE

Families who are low risk of SIDS need to be aware of any situations which increase the risk, like having alcohol and need to plan for this. Families who intend to bed share need to plan and take on board the advice from practitioners.

- Never drink alcohol
- Never take illicit drugs
- Some prescribed drugs will cause drowsiness if these have been taken never bed share
- Ensure there are no pillows, sheets, blankets or other items in the bed that can overheat the baby or move over the baby's head. A high proportion of babies who die of SIDS had their heads covered with loose bedding.
- Make sure the baby cannot fall out of bed or become trapped between the mattress and the wall
- Never leave the baby alone in bed

The three key messages are the same even when bed sharing

- **Put babies on their back for every sleep**
- **Babies should sleep in a clear flat sleep space**
- **Keep babies smoke free day and Night**

Talking to families about safe sleep

It is important that in Derby and Derbyshire that all practitioners and professionals are able to have quality conversations about safe sleep practice with parents and families of babies under a year old. Practitioners need to feel confident to give clear and consistent information taking into consideration the parent's level of understanding, language and cultural needs.

It is important to engage all families but with a particular emphasis on vulnerable families.

- Be open and non- judgmental
- Non directive communication style to find out what parents already know
- Open questions to avoid yes and no answers
- Active listening skills- reflective, summarising and the use of open body language
- Use of resources to ensure that the information is shared in a way that parents can understand and will remember
- Explain why we want to see where a baby sleeps day and at night

Talking to families about Bed sharing

- Shock messages don't work
- Beware of assumptions, check out all parents understanding
- Explore why a family wishes to bed share
- Every family needs a plan to avoid accidental bed sharing
- Families need to know they are high risk to SIDS and why, we know families are more likely to follow advice if they know why
- Families at high risk of SIDS should be advised not to bed share
- All families need the tools and information with clear advice to enable them to make an informed choice
- Support low risk breastfeeding families in enabling mum to find a comfortable position to feed baby in whilst lying down in bed, to support ongoing breastfeeding and reduce the risk of mum feeding in more dangerous positions, see UNICEF UK

Example of a risk assessment tool:

Safe Sleep Practice and Bed Sharing – Assess Your Babies Risk Every Sleep - Make Every Sleep Count		
Question	**Yes/No**	**Reason**
Do or have either you or your partner ever smoked? (including pregnancy)		Smoking increases the risk of sudden Infant Death Syndrome
Have you or your partner recently drunk alcohol?		Alcohol use increases the risk of Sudden Infant Death Syndrome
Have you or your partner recently taken any drugs or prescribed medication that may make you sleepy?		Taking any drugs or prescribe medication that can make you sleepy increases the risk of accidental death whilst bed sharing
Are you or your partner very tired (less than 4 hours sleep in 24 hours)		Excessive tiredness will affect your sleep pattern and is a risk if you bed share
Was your baby born early (before 37 weeks) or weighed less than 2.5kg or 5.5lbs		Babies who are born early or who are very small are at higher risk of Sudden Infant Death Syndrome if safe sleep practice is not followed
Have you or your baby got a cold or viral illness or are unwell in any way		It is not advised to bed share if you or your baby are unwell or your baby has signs of a viral illness
If you answer yes to any of these questions you are advised not to bed share due to the increase risk of Sudden Infant Death Syndrome		
Please follow safe sleep advice and contact your Midwife, Health Visitor or Family Nurse if you have any questions		

Adapted from NHS North Lancashire leaflet 'Where might my baby sleep'

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Safe Handling

The Research

Non-accidental head injury involving injury to the brain is the most serious form of physical abuse and can have serious consequences for a child's future development and wellbeing. Non accidental head injury is the leading cause of death among children who have been abused.

Non-accidental head injury occurs most commonly in children less than two years of age with an estimated prevalence of 1:3,000 in babies less than six months old. Boys appear to be affected more commonly than girls. Non-accidental head trauma involves inflicted injury to the brain or bleeding within the structures around the brain. The consequences can lead to significant long-term disabilities including cerebral palsy, visual problems, epilepsy, learning and behaviour problems. (CORE INFO and NSPCC 2014).

Altman et al (2010) also concluded that fathers and male partners are nearly 5 times as likely as mothers to shake an infant.

This form of child abuse differs in a number of ways from other more common and more visible forms of abuse;

1. A single event may cause catastrophic outcome
2. Often there are no visible sign of injury
3. There is frequently no intent to harm the child
4. The immediate and follow on outcome is worse than with other cause of head injury in childhood (Bruce & Zimmerman, 1989)

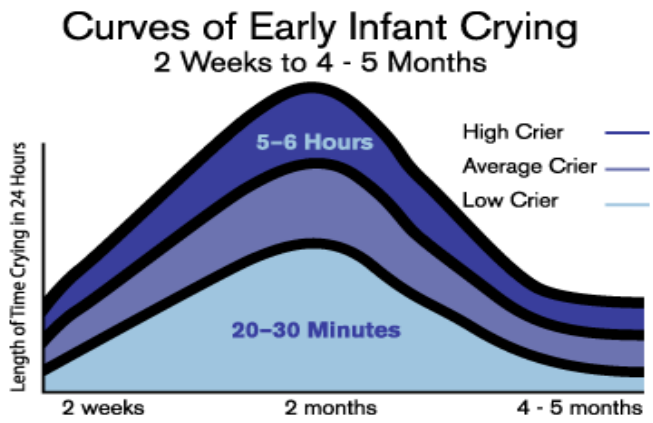
Shaking events do not appear to be related to ethnicity, class or family circumstance (Sinal et al., 2000) although risk does increase in families where there are more stressors and fewer resources (Sanders et al.,2003).

Crying

Parents report to practitioners that the persistently crying of their baby is a stressful. Long and Johnson (2001) highlight that those parents and carers who complain to professionals that their baby cries excessively, actually do have a baby who cries more frequently and for longer than most. This can promote feelings of living on the edge, feelings of a loss of control and social isolation.

Bar et al (2000) in their study concluded that babies who cry excessively will do so despite the quality and level of parenting provided and all babies have a normal crying curve which starts at 2 – 3 weeks with a peak at 5 – 6 weeks.

Normal Crying Curve



Ronald G. Barr
PNAS October 16, 2012 109 (Supplement 2) 17294-17301; first published October 8, 2012
https://doi.org/10.1073/pnas.1121267109

Derby and Derbyshire have an established and embedded Parent Education Programme (PEP). This was developed in 2008 in response to Serious Case Reviews following the deaths and serious injury of young babies.

Shaking the Baby is Just Not the Deal

This is a research based programme developed in Australia (Shaken Baby Prevention Project) and has been adapted for local use. The programme consists of going through a leaflet with both parents and showing the DVD and then asking the parents to sign a commitment paper that they agree to support and protect their baby's head. This is delivered before the baby leaves hospital. If the parents do not receive the PEP before they leave hospital or they have a home delivery, it is the responsibility of the Community Midwife to deliver the programme at their first visit.

The Health Visitor (HV) will then check the parents have received the programme and have understood the information. If there are any families who still have not seen the DVD the HV will signpost them to the video which is available on YouTube and talk to the parents about safe handling and managing a crying baby.

When delivering the programme it is particularly important that fathers are fully engaged and sign the commitment paper. It is important to ensure multi–agency partners have a full understanding of the programme and are encouraged to reiterate the messages at contacts with parents and babies this is particularly important with vulnerable families.

ICON

ICON is a programme which was launched nationally from National Health Service England (NHSE) in 2020. This is a pilot project and all midwifery units have been provided with leaflets to share with parents prior to discharge. The information within ICON is similar to the information from the Derby and Derbyshire PEP. ICON is based on research from USA.

ICON suggests 7 intervention points:

1. High School: description. Link to lesson plan and lesson
2. Hospital Based: description. Link to leaflet and script and commitment statement
3. Community Midwife home visit: reiteration of 4 point message
4. Health Visitor/Family Nurse Primary visit: reiteration of 4 point message
5. Health visitor/Family Nurse topic specific contact: dedicated contact discussing normal crying and exploring how parents/caregivers are coping.
6. GP 6/8 week check: link to questionnaire
7. Any professional involved with babies to provide opportunistic support/advice

Derby and Derbyshire Safeguarding Partnership and the Maternity Transformation Programme support the continued use of the local Parent Education Programme 'Shaking the Baby is Just Not the Deal'.

As the development of ICON continues it will be useful to consider how ICON can be utilized with the local programme. Some areas of development could be the multi-agency approach to early intervention in school and the GP questionnaire.

Key Messages

- Non-Accidental Head Injury is the most common form of abuse in babies under 2 years old
- The immediate and long term impact is far worse than other head injuries
- Fathers or males partners are 5 times more likely to shake a baby than the mother
- Vulnerable families with more stressors in their life are more likely to shake a baby
- Persistent crying is a known factor and not necessarily due to poor parenting
- The Derby and Derbyshire Parenting Education Programme must be delivered to all parents including all fathers or partners that will be caring for the baby

Key actions for Practitioners

- Practitioners need to understand the curves of infant crying to know how and when to support parents
- Midwives lead on delivering the PEP to all parents of babies who live in Derby and Derbyshire no matter where they have been born
- Both parents need to receive the programme and the commitment paper should be signed by both parents
- Any parents who do not receive the PEP before they leave hospital or have had a home delivery will receive it at the first visit by the midwife
- Health Visitors will check and record the understanding of the PEP by the parents. If the parents have not seen the video they will be signposted to it and the safe handling of babies and managing crying will be discussed with the parents.
- There needs to be a recognition that crying is stressful for parents, particularly fathers who may need additional input to support the management of an infant who is reported to cry excessively
- The research tells us that young parents may find the transition to parenthood challenging and may require additional support
- There needs to be a multi-agency understanding of the PEP and the messages to be re-enforced with families who have the care of babies
- The programme has been and will continue to be reviewed and audited for its reliability and efficacy taking into account the views and understanding of parents

Safe Space

The Research

Accidents to children are a significant health issue, being a major cause of preventable death, serious injury and long-term disability across the UK. Threats to breathing such as suffocation, strangulation and choking cause the highest number of deaths. The Child Accident Prevention Trust reports that each year, an average of 60 children under five years die from injuries in and around the home.

Any child can suffer a serious accident, but children living in poverty are most at risk. Children living in poverty are 13 times more likely to die in preventable accidents (RCPCH -The Impact of Poverty and Child Health 2018). The reasons for this include; unaffordable safety equipment, buying cheaper products that don't comply with safety regulations, literacy, single parents, maternal depression, homelessness or overcrowding.

Asphyxiation (via choking, strangulation or suffocation) is the leading cause of accidental death among the under-fives and on average, 28 children die a year (Child Accident Prevention Trust).

Nappy Sacks

Nappy sacks can be extremely dangerous to babies and young children, and can easily cause suffocation if near the mouth and nose. Their flimsy material means that they easily cling to the face and are 'sucked in' against the nose and mouth, and prevent breathing. They are flimsy enough to float in the air and can then land in a cot or Moses basket.

Nappy sacks are a common sight in many nurseries and changing bags. Often fragranced, and in a range of bright colours, they are especially attractive to young children. Young babies under six months naturally grasp things and pull them to their mouths, but then find it difficult to manipulate out of their mouth and let go.

At least 18 children have suffocated from a nappy sack (Child Accident Prevention Trust) Parents and carers are generally aware of the dangers posed by plastic bags, but do not make the same link to nappy sacks and so are less likely to take the same safety precautions.

Babies are at particular risk of suffocation and choking from plastic sheets and bags for a number of reasons:

- They cannot understand the risks associated with their actions
- They seek to explore the world around them by, among other actions, putting articles in their mouth to experience taste and texture
- They do not have the manual dexterity to remove a thin plastic covering that is "adhering" to their face or is in their mouth

Final February 2021: Authors - Juanita Murray and Kayleigh Noble: Chair and Vice Chair of the Derby and Derbyshire Keeping Babies Safe Steering Group

Blind Cords

Looped blind cords and chains can strangle babies. The Child Accident Prevention Trust report at least 33 children have died in the UK because of blind cords since 2001. Research has shown that most accidental deaths involving a blind cord occur in the bedroom and more than half occur when the child is around 23 months (although deaths have occurred in children aged 16-36 months). **It is important to remember that when babies are able to stand in their cot there are risks from blind cords.**

Babies and toddlers heads weigh proportionately more than their bodies and their muscle control is not yet fully developed which means they are unable to free themselves if they become entangled. In addition their windpipes are not yet fully developed and they therefore suffocate more quickly if their necks are constricted. Strangulation by blind cord can happen quickly and quietly, often with carers close by, unaware of what is happening. It can take just 15 seconds for a toddler to lose consciousness if they get tangled in a blind cord. Death can occur in 2-3 minutes.

Slings

Tragically some babies have suffocated in baby slings. This happens when the baby is in a c-shape, with their chin on their chest which restricts their breathing, or when their face is being covered by a parent's skin or clothing. There is an increased risk for babies born prematurely or with a low birth weight. Because babies do not have strong neck control, their heads are more likely to flop forward, chin-to-chest, restricting the airway. The safest baby carrier is one that keeps the baby upright and firmly against the parent's body. Parents should ensure they keep the babies chin of their chest to keep their airway free for breathing.

Car Seats

It is essential and the law that when babies travel in a car or similar they are placed in a car seat. However, journey times should be limited as there is a risk of the baby experiencing breathing difficulties if sat upright for too long. There is no published research evidence that suggests how long it is safe for a baby to travel in a car seat. However, the Lullaby Trust, safety experts and car manufacturers recommend that babies should not be in a car seat for longer than 2 hours at a time and they should be taken out frequently. There should be regular breaks where the baby is taken out of the car seat to allow them to stretch and move about. Ideally, a second adult should travel in the back of the car with the baby. If the baby changes position, or slumps forward the car should be stopped immediately, baby taken out and readjusted.

Car seats are designed to keep babies safe whilst travelling, not as a sleeping space. It is likely a baby may fall asleep whilst travelling, but they should be taken out as soon as the destination is reached and placed on a firm, flat surface to sleep. The calculation of time is the time a baby spends in the car seat not the travelling time. This is an important message when parents are considering travel systems.

The law requires all children travelling in the front or rear seat of any car, van or goods vehicle must use the correct child car seat until they are either 135 cm in height or 12 years old (which ever they reach first). When the child is no longer in a car seat they must use a seat belt.

It is the driver's responsibility to ensure that children under the age of 14 years are restrained correctly in accordance with the law.

Button Batteries

If a button battery gets lodged in a child's food pipe, it can cause catastrophic internal bleeding, life-changing injuries and death. Most batteries can pass through the body without a problem, but if a lithium button battery gets stuck, chemicals from the battery react with saliva and can erode tissue in the child's gut in just 2 hours. A battery can also be dangerous if it gets stuck in a child's nose or ear.

Children most at risk are those aged 1-4 years. Crawling babies are at particular risk as they explore their environment by putting things in their mouths. The Child Accident Prevention Trust state that at least 2 children a year died as a result of swallowing a button battery in the UK. Great Ormond Street Hospital reports they see one child a month with burns caused by button batteries.

Typically small children take batteries from gaming headsets, key fobs, hearing aids, remote controls, but they can be found in toys, books, cards, many places. They may find spare batteries stored in a drawer. Flat batteries are still dangerous and can cause injury.

It is not always obvious if a child has swallowed a button battery; if it gets stuck in their food or wind pipe there are no obvious symptoms. However, a child may gag or cough, be sick, have some pain in their tummy or throat, be tired, appear quieter than usual or have a reduced appetite.

If it is suspected a child may have swallowed a button battery they must be seen in A&E immediately.

Key Messages

Nappy Sacks:

- The best advice is to simply stop using nappy sacks
- Educate about storing plastic bags/nappy sacks out of reach
- Do not place nappy sacks in cot, pram or buggy
- Do not store nappy sacks near an open window or ventilation, they are light weight and float in the air and can land in a baby's cot

Blind cords:

- Keep blind cords away from cots/bed/play pen/changing table/highchair.
- Do not hang toys or objects that could be a hazard on a cot/bed.
- Do not hang drawstring bags where a small child could reach.
- Do not cut the cords – this makes them more dangerous. One cord could become much longer, increasing the risk of entanglement, or the cut cord could form a new loop.
- Fit a tidy, tensioner or cleat to the blind loop.

Baby Slings:

Use a sling that supports the development of baby's spine, neck and hips, whereby the baby's' weight is evenly distributed.

Parents to ensure they can see their baby to ensure that their face isn't restricted.

Follow the **TICKS** advice from the UK Sling Consortium

- Keep your baby in **T**ight
- **I**n view
- **C**lose enough to kiss
- **K**eep their chin off their chest
- **S**upport their back

Car Seats:

- Take regular breaks on long car journeys and limit journeys to no longer than 2 hours
- Remove baby from car seat as soon as destination is reached
- Remove extra layers/thick clothing before placing baby in car seat
- Ensure car seats are fitted correctly
- Ensure the harness is level with child's shoulders at the top and is not too loose or too tight
- Ensure child seat is suitable for child's weight and size
- Never buy a second hand car seat, unless confident about its history

Button batteries:

- Store spare batteries securely
- Know which toys and gadgets use button batteries

- Check the home for any items that may hold button batteries and secure them safely out of reach
- Dispose of dead batteries immediately

Key actions for Practitioners

Those working with children and families are ideally placed to help reduce preventable deaths. Home visits are an ideal opportunity to discuss effective safety practices. A home safety checklist is a practical tool that can help empower parents. Education is more effective when combined with providing and fitting safety equipment such as smoke alarms and safety gates. There are opportunities to integrate safety advice within all contacts with parents/carers. Equipping them with an understanding of how a baby will develop can help them to stay one step ahead and anticipate future risks.

Second-hand Equipment

When buying a second-hand product, such as a cot, ensure that all the parts are present, along with the instructions from the manufacturer.

The safest option would be to always use a new mattress; however, this is not always possible. It is common that families want to use second-hand mattresses, either from friends/family or from their previous children. The Lullaby Trust state there is some evidence that there is re is an increased risk of SIDS when using a second-hand mattress brought in from outside of the family home, although the link is not yet proven.

If wanting to use a second-hand mattress, to reduce the risk, the mattress should be completely covered in a waterproof covering, with no rips tears and is in a good condition. The mattress should also be firm and flat, with no sagging. Ensure the mattress has been stored somewhere clean, dry and smoke-free. The mattress should be thoroughly cleaned and dried before making it up with fresh bed clothes.

Car Seats

Never buy a car seat second hand unless you are assured of its history. Car seats are "one hit wonders" – something that must never be used again if involved in an accident.

If involved in an accident, or if dropped, the internal structure can be damaged and it will therefore not effectively protect the child. When buying a second-hand car seat, in most cases, it is not known for sure if it's been damaged, and that could make the difference between life and death. If the family buy a second hand car seat from a close friend or relative they may know the full history of the product, however, an unknown seller may not be as honest about the history of the car seat.

Baby Safe Champions

The vision for Derby and Derbyshire is to have Baby Safe Champions within the wider partnership. This will include:

- The main Health Providers which includes Midwifery, Health Visiting, Emergency Departments, Paediatric Wards, EMAS
- Children's Social Care including Early Help and Early Years
- Police
- General Practice

The role and responsibility of the Baby Safe Champions:

- Be a resource regarding baby safety within their team and agency
- Attend training and updates on baby safety
- Disseminate any learning from child practice reviews and CDOP regarding baby safety
- Raise the awareness of the importance of Safe Sleep, Safe Handling and Safe Space and the use of the strategy and toolkit to support families with babies

The Baby Safe Champions will be supported and updated by the Keeping Babies Safe Steering Group for Derby and Derbyshire.

Toolkits

The toolkits are a resource available to all professionals and practitioners to support the messages that are delivered to families. The information is research based. There are useful websites and information that can be used with families who have specific learning or language needs. Briefings and learning from CDOP and safeguarding practice reviews will also be available for reference.

The toolkit will be stored on a shared drive that can be easily accessed. The Champions can then use the toolkit within their service, by updating their own websites and sharing the information amongst colleagues; encouraging use with families and carers.

The toolkits will be updated regularly, by the Lead Nurse for Child Death, to ensure that new information is added and any information that is no longer relevant updated or removed.

Training Strategy

The Baby Safe Champions and the wider partnership are encouraged to attend any training opportunities on keeping babies safe. Keeping babies safe should be a golden thread in all safeguarding training.

Specific training:

- Level 3 Safeguarding Partnership Training
- Training for Baby Safe Champions which includes the Lullaby Trust training on safe sleep

Outcomes and Assurance

The Safeguarding Childrens Partnership and the Child Death Review Partners/CDOP will require assurance of the effectiveness of the Keeping Babies Safe Strategy. The Strategy will be updated and monitored by the Keeping Babies Safe Steering Group for Derby and Derbyshire. This will be achieved by:

- Taking account and responding to learning themes and recommendations from Child Practice Review and CDOP
- Training compliance and activity around baby safety
- Audit of the Safe Sleep Strategy
- Audit of the Parent Education Programme Shaking the Baby is Just not the Deal
- Activity and outcomes of the Baby Safe Champions
- Local analysis of the factors associated with the deaths of babies through CDOP

Reporting

The effectiveness of the strategy and the Baby Safe Champions will be reported through the Keeping Babies Safe Steering Group to CDOP. The outcomes and impact will then be reported to the Child Death Review Partners and the Derby and Derbyshire Safeguarding Children's Partnership.

Keeping Babies Safe is a priority of the Derby and Derbyshire Safeguarding Children Partnership and the Child Death Overview Panel.

It is everyone's business to keep babies safe and help prevent further deaths of babies in Derby and Derbyshire.

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Safe Sleep

Basis: Baby Sleep info Source

https://www.basisonline.org.uk/

Caring for your baby at night a guide for parents (UNICEF)

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Shaking the Baby is Just Not the Deal Video:

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Safe Space

Baby Sling Safety T.I.C.K.S (Baby Sling Consortium)

The Child Accident Prevention Trust

https://www.capt.org.uk/Pages/Category/safety-advice-injury-types

The impact of poverty on child health: Josephine Tucker (RCPCH 2018)

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