

From Jo Churchill Parliamentary Under Secretary of State for Prevention, Public Health and Primary Care

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Your Reference: Our Reference:

Mr Alan Anthony Wilson HM Senior Coroner, Blackpool and Fylde PO Box 1066 Blackpool FY1 1GB

18th November 2020

Dear Mr Wilson.

Thank you for your letter of 14 September about the death of Isaac Jakob Newton. I have noted carefully your concerns about public recognition and awareness of the risks of cosleeping, where parents or carers sleep on a bed or sofa or chair with an infant.

First, I would like to offer my sincere condolences to the parents and family of baby Isaac. I can appreciate how deeply distressing Isaac's death must be for them. I note with great concern, that this is the fourth inquest you have heard this year involving the deaths of young children as a consequence of co-sleeping.

I wish to assure you that we recognise the need to support professionals working with mothers and fathers to provide sensitive and attuned parenting, particularly during the first months and years of life, giving individual tailored support for the child and its parents or carers. It is vital that families and their children who need extra support are identified early and receive tailored support. That way, we can prevent problems from arising in the first place, rather than dealing with the consequences.

It is deeply concerning that some infants suffer serious harm, or even death, and each and every case is a tragedy. We are determined to do everything we can to protect these children, particularly as we respond to the increased risk of hidden harms during the Coronavirus pandemic.

With Ministerial colleagues in the Department for Education (DfE) and Home Office, we have welcomed the recommendations of the Child Safeguarding Practice Review Panel in its report, published in July 2020, into sudden unexpected death in infancy in families where the children are considered at risk of significant harm¹.

¹ https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death

The report, which you have referenced, highlights that despite broad success embedding safer sleeping messages with parents, there are still persistent issues for some families when it comes to acting on those lessons. The report is clear that this is a complex issue. We will implement the three national recommendations:

- The Child Safeguarding Practice Review Panel and DfE to work with the
 Department of Health and Social Care (DHSC), NHS England and the National
 Child Mortality Database to explore how data collected through child death reviews
 can be cross-checked against those collected through serious incident notifications
 to support local and national learning;
- As part of the refresh of the high impact areas in the Healthy Child Programme and the specification for health visiting, Public Health England should consider how the learning from this review can be embedded within the transition to parenthood and early weeks; and,
- DHSC to work with key stakeholders to develop shared tools and processes to support front-line professionals from all agencies in working with families with children at risk to promote safer sleeping as part of wider initiatives around infant safety, health and wellbeing.

In relation to guidance available to healthcare professionals, NICE Clinical Guideline 37, *Postnatal care up to 8 weeks after birth*², sets out that healthcare professionals should inform parents and carers that there is an association between co-sleeping and Sudden Infant Death Syndrome (SIDS). They should also inform parents and carers that the association between co-sleeping and SIDS is likely to be greater when they, or their partner smoke; and that the association between co-sleeping and SIDS may be greater with parental or carer recent alcohol consumption or drug use, as well as low birth weight or premature birth.

The accompanying Quality Standard (QS37³) sets out that 'women, their partner or the main carer are given information on the association between co-sleeping and SIDS at each postnatal contact'.

You may wish to note that CG37 is in the process of being fully updated and consultation on the updated draft guideline ends on 27 November 2020⁴. Until the expected publication of the updated guideline in April 2021, CG37 remains current and health professionals are expected to adhere to and provide care in line with NICE guidance. I am advised by NICE that the concerns in your report will be considered as part of the guideline update.

² https://www.nice.org.uk/guidance/cg37

³ https://www.nice.org.uk/guidance/qs37

⁴ https://www.nice.org.uk/guidance/indevelopment/gid-ng10070

To promote safe sleeping messages regarding babies and co-sleeping, Public Health England, working with the Lullaby Trust, have created two short films that have been released this year. The films give advice on caring for babies during the Covid-19 pandemic⁵, and when your baby won't sleep⁶.

Advice on safe sleeping is built into the Healthy Child Programme, the early intervention and prevention public health programme that focuses on a universal preventative service for children and families. The Programme provides an invaluable opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes.

Public Health England advise that in Quarter 3, 2020/21, it plans to publish refreshed commissioning and delivery guidance for the Healthy Child Programme, that includes safer sleeping discussions at specific interactions between health visitors and school nurses with parents and carers. In addition, Public Health England plans to publish refreshed High Impact Areas for the Healthy Child Programme in Q3, 2020/21 which will highlight the potential for harm from new hazards such as cot bumpers and sleeping pods and the dangers associated with SIDS.

Finally, in July 2020, a major new review into improving health outcomes in babies and young children was launched and is being led by the Early Years Health Adviser, Andrea Leadsom MP⁷. The review will consider the barriers that impact on early-years development, including social and emotional factors and early childhood experiences and seek to show how to reduce impacts of vulnerability and adverse childhood experiences in this stage of life.

I hope this information is helpful and demonstrates the range of action being taken to raise awareness and target action to prevent the risk of future tragic deaths such as that of Isaac. Thank you for bringing these concerns to my attention.

GONS SUCCELL

JO CHURCHILL

⁵ https://www.youtube.com/watch?v=kKohoV7LPOo

⁶ https://www.youtube.com/watch?v=JAxO3JBzeT8

⁷ https://www.gov.uk/government/news/new-focus-on-babies-and-childrens-health-as-review-launches