Safer Sleep – Merseyside Police

An initiative to educate, raise awareness and promote safer sleep practices.

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Key details

Does it work?	Smarter practice
Topic	Vulnerability and safeguarding
Organisation	Merseyside Police
Target group	Adults Communities Families

Smarter practice

Overview

Video Transcript

Sudden infant death is catastrophic for everybody – for the family, of course, but actually for the wider community, for the grandparents, for the friends, for the professionals involved. So this is something that everybody can deal with, so the information is given to new parents when they have a baby, but they're given a lot of information at the time. And it's a reinforcing that message. And if there's a way that other agencies can assist with that, that's all better.

Safer sleep came from an initial request to look at providing some enhanced awareness around domestic abuse intensification week. In particular, so we could identify potential risks that are there for new parents, for new babies, and try and mitigate them with officers by saying, "If you can recognise these risks, then you can communicate them to the communities and hopefully reduce

the risk of infant death .”

Initially, it was an A4 piece of paper, which was supposed to be printed out, taken to every incident, filled in, scanned on and returned to the NHS. We then started sort of exploring, “Well, how can we make this more efficient?” So we did a whole lot of steps and a whole load of work and developed an automated system, so when the officer clicks ‘submit’, that notification gets sent to the NHS, direct to one of their safeguarding teams.

I’m a doctor and I really want the police to do their job to tackle crime and keep the population safe. But I also want them to just think a little bit if they’re in a building or a house , for whatever reason, and they see something that’s possibly not safe sleep practice, that they would think, “Okay, I can refer this into the NHS and that’s a supportive gift that I can give to that family, and the NHS can take it and run with it and give the family the support that they may need to mitigate the risks from that unsafe sleep practice.”

What I really, really want to drive with officers is professional curiosity, and the responsibility to take action and do something about vulnerability that they are seeing within addresses . We have a prevention strand within Merseyside, and one of the pillars of that strand – and of the prevention strategy – is to prevent harm. And there is no greater need than to prevent the loss of a child.

We know we’re given information universally when people are normally quite settled, they’ve got that support from family members. But we know families also could hit crisis point, and that’s when Merseyside Police tend to be in those properties , so they’re getting a truer reflection of those current situations. And at that point, that notification has then allowed our staff and our health visiting team to contact the family and offer additional advice and support.

We don’t want officers to go in and be medical professionals. We want them to think, “I’m not quite sure that that’s right. And, you know, I’m concerned that the baby is in a difficult or a dangerous situation. Perhaps the family needs some support and advice.” So we’re not there to be punitive and tell them, “We’re going to report you further on through the police process or through social services.” This is for support through the NHS.

We need to be mindful that unsafe sleep practices aren’t necessarily just going to occur amongst the communities that are criminally active . It’s quite feasible that we could go to a house of somebody who is a victim of crime and we notice an unsafe sleep practice. What we’ve really got to

be mindful of with officers is that they are switched on to those unsafe sleep practices, irrespective of the property that they may be in.

Previous to this, we'd have to do a vulnerable person referral form, which could take anywhere from half an hour to potentially a couple of hours . The whole point of this and the whole implementation is that it can take 90 seconds. And also, on the other end, it's not having to go through a panel to assess it, to decide whether it hits a threshold for referral. Actually, it goes straight to the people who can make true impact straight away.

This is a real golden opportunity for us to provide support for the people that matter – the parents and the children – but also remove our officers from what could be a really life-changing situation that they deal with. We want them to be happy and healthy at work and not have to deal with such traumatic incidents.

This is multi-agency work and action. I've been in safeguarding for about ten years now, and it has often been something theoretical. And this has just been real action. This is really changing professional behaviour and having an impact on the families and the population who are on the receiving end of our care.

A child death is a traumatic experience. It's tragic. No one should have to experience it. If we can reduce just that number by one, then we're all doing something right. That better collaborative working with other agencies is how we can do that.

It's such an important topic and such a simple solution to it, and it's not being done anywhere else. And we know that it could have a massive impact if we look to push it wider. It's a massive amount of pride to sort of be involved in something that's been so well received and could have such a positive impact. Of course, it's difficult to measure, but doing the right thing is never the wrong thing.

If you've ever dealt with a sudden infant death, and I have, I dare say it's the most horrendous thing you've ever had to deal with and probably ever will. So the reality is, if I can make a contribution – even if it's a small contribution – to reducing sudden infant deaths in the future, it's an absolute valuable use of my time, and also everyone else's internally and externally too.

The Safer Sleep initiative is part of Merseyside Police's 'Prevention' programme. 'Prevention' is a whole-force approach, focusing on the community and driving sustainable and meaningful change.

Prevention aims to provide officers, staff and partners with the support, skills and resources to prevent crime and harm. The Prevention portfolio includes multiple interventions which in the long term will result in fewer offences, fewer victims and therefore, less demand on policing.

The number of sudden, unexpected deaths of infants (SUDIs) with risk factors **increased from 46.4% in 2019/2020 to 68.2% in 2020/21**. Between 2019 and 2022, the overall number of SUDIs doubled in Merseyside alone.

Merseyside Police identified an opportunity to better use time spent at addresses where infants were present and enhance the overall safeguarding service provided to families. The force, working closely with Mersey Care NHS Foundation Trust, adopted a problem-solving and partnership-oriented approach to prevent SUDIs. This activity resulted in the Safer Sleep initiative.

The overall aim of the Safer Sleep initiative is to educate and raise awareness among the public, promote safer sleep practices and prevent SUDIs. Other aims include:

- improving partnership working with the NHS, specifically Liverpool's health visitors (HVs)
- supporting families
- building trust in communities

Problem

Rise in cases of SUDIs

The sudden, unexpected death of an infant is an extremely tragic and traumatic experience for any family member. It also has a significant impact on the officers and staff who respond and investigate.

Between April 2021 and March 2022, 104 children lost their lives in the Merseyside region. This number was attributed to factors including the cost-of-living crisis. Officers attending cases where infants were present recognised that parents were faced with increasingly difficult choices, such as feeding their children or heating their homes. This resulted in unsafe sleep practices (for example, overcrowded sleeping or sleeping in one heated room on sofas or other makeshift beds).

These decisions potentially contributed to infant fatalities. The force, and other relevant agencies, recognised that people in crisis were often unknowingly putting their infants in danger. They either forgot or were unaware of key messages on safe sleep.

Limitations to reporting unsafe sleeping practices

Prior to the Safer Sleep project, there was no specific unsafe sleep training or referral mechanism.? As part of safeguarding training, police officers are trained to look for areas of risk that would indicate potential neglect, such as the state of the house, amount of food in cupboards, levels of uncleanliness or disrepair.?Specific unsafe sleep risks such as bed sharing, lying face down or excessive toys and blankets would not be identified.?This area would in most circumstances fall outside legislative boundaries and into a requirement for professional support and advice.

The Safer Sleep initiative sought to use an opportunity, by maximising our safeguarding delivery to families in circumstances beyond the application of law.? Identifying this type of risk is therefore, an entirely new process, to support the work delivered by HVs.

Demand for a joint agency response

During the research and development phase of the Safer Sleep project, the Child Safeguarding Practice Review Panel published **Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (2020)** . This directly reflected on a need for a multi-agency response to reducing the risk of SUDIs:

'There needs to be better links between the work in local areas to reduce the risk of sudden unexpected death in infancy (SUDI). This work needs to be embedded in multi-agency working and not just seen as the responsibility of health professionals.'

Recommendation	Action by
• We recommend that the Child Safeguarding Practice Review Panel and the Department for Education work with the Department of Health and Social Care, 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.	• Child Safeguarding Practice Review Panel
• We recommend that the Department of Health and Social Care works with key stakeholders to develop shared tools and processes to support frontline 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.	• Child Safeguarding Practice Review Panel

In January 2023, the National Child Mortality Database published its **Sudden and Unexpected Deaths in Infancy and Childhood** thematic report. This set recommendations for multiple agencies in the UK to ensure a reduction in SUDIs.

Recommendation	Action by
• Ensure agencies responsible for conducting the statutory Joint Agency Response are compliant with national guidance including the joint attendance of police and healthcare professionals to facilitate appropriate support of families and achieve good quality data collection.	• National Police Chiefs' Council • Commissioners of Joint Agency Response processes • NHS England • Department of Health and Social Care

Response

These recommendations were included in the reports, highlighting the importance of agencies working together to support families and promote safer sleeping practices to prevent SUDIs. The Safer Sleep app seeks to improve the joint response to the rising instance of SUDIs. It is designed to create a stronger foundation of partnership working and data sharing to prevent SUDIs in the first instance.

In 2022, during domestic abuse intensification week in Merseyside, a police constable was asked to deliver a briefing to frontline officers to raise awareness of safer sleep practices. The briefing was supported by a publication on safer sleep also targeted at frontline officers.

However, it was recognised that more could still be done to inform officers about safer sleep practices and provide a safeguarding tool which could deal directly with the concerns of unsafe sleeping practices.

Initial scoping

Taking into consideration the above problems, there was a clear need for a safeguarding mechanism allowing officers to directly contact the NHS Mersey Care safeguarding team. There was also a need to improve the joint agency response.

Merseyside Police designed the Safer Sleep initiative. Safer Sleep was designed to be a more supportive and holistic approach to working with families to address unsafe sleep practices which could potentially lead to a SUDI.

An initial scoping exercise found there were no existing processes or any best practice in this area. Merseyside Police liaised with the NHS, the Lullaby Trust charity, NHS Mersey Care and the Merseyside Police Violence Prevention and Response Unit.

NHS Mersey Care acknowledged that there was an opportunity for increased engagement from officers to identify unsafe sleeping practices. Both agencies could work together to promote Safer Sleep and further prevent and reduce numbers of SUDIs.

Stakeholder engagement led to an agreement that the new initiative should use officers to increase interactions with the public, in particular parents, to support this agenda.

Partnership work

Following the initial proposal for the Safer Sleep initiative from Merseyside Police, NHS Mersey Care proposed the use of a pre-existing referral form that would meet the required information specifications for subsequent clinical decisions. It was proposed that officers use a paper form when they spot unsafe sleeping practices, fill out this form and return a digital version to the NHS Mersey Care safeguarding inbox. Doing so would then notify the safeguarding team and allow them to support where needed.

During this time, a Safer Sleep pilot was proposed for the Liverpool area, for which training processes were proposed.

Safer Sleep logic model

Problem	• Between April 2021 and March 2022, 104 children lost their lives in the Merseyside region. • Limitations to reporting unsafe sleep practices. • Vulnerable person referral form (VPRF) responses weren’t efficient in reporting. • Demand for a multiagency approach/partnership work to tackle SUDIs.

Response	• Initial scoping and activities to raise awareness. • Safer Sleep app development and usage. • Software and processes developed. • Data sharing agreements (between agencies) and formal partnership work.
Outputs	• Increased partnership work with Lullaby Trust, NHS Mersey Care. • Increased use of Safer Sleep app to report concerns. • Increased confidence of officers attending scenes.
Outcomes	• Fewer incidents of SUDI. • Increased public confidence and awareness among, leading to safer sleeping practices.

- View logic model as a poster

Implementation

Developing the software

- NHS Mersey Care had an existing safeguarding notification form in place for use with other agencies. However, when multiple agencies come together, it is important to streamline the process to work best with multiple systems. Automation using Microsoft 365 tools was proposed. This would allow officers to input the data digitally rather than via a paper form, which would have to be converted.
- As a result of this decision, the first version of the automated Safer Sleep process was designed on Microsoft 365 via Microsoft Forms. It was agreed that the process would be automatic so that when officers filled out the form, it would automatically populate a notification email directly to NHS Mersey Care. This would also add the data to an Excel document, accessible by the safeguarding team. This decision greatly reduced the resource required to complete the process, thus addressing the issue of the more time-consuming vulnerable person referral form (VPRF) process already in place.
- A borough-oriented geographical tick-box option was later added. This allowed officers to select the area the home was in and ensure that the notification was sent to the correct NHS safeguarding team.

Data sharing agreements between agencies

- As Safer Sleep is an initiative built to share data with the NHS, part of the setup involved developing a thorough data protection impact assessment (DPIA) and information sharing agreement (ISA).
- A standard approach to data sharing was broadly adopted. However, there are elements in the ISA that allow the information to be shared quickly and efficiently.
- Firstly, consent from a parent or guardian for completion and submission of the notification is not required. As the notification concerns the safeguarding of children, it is considered of substantial public interest. Therefore, permission is not needed for the information to be shared with health services.
- Information is shared using a transport layer security (TLS) email system, ensuring adequate security is in place when transferring the notification data.
- Once the notification is submitted, it is automatically sent to the relevant safeguarding team, bypassing the general NHS shared mailbox. By going to the safeguarding team directly, rather than being processed and forwarded, the time for processing and clinical decision-making is reduced.
- There is an agreed three-day review and initial decision period by the NHS on receipt of the notification. For the most part, the notifications are dealt with as they are received. However, the three days allows for a period of grace over bank holiday weekends when staff numbers are reduced.
- Information is kept indefinitely in a child’s NHS record. These records are usually archived when the person turns 19 unless there are special educational needs, in which case records remain active until the child/young person is 25 years old. Merseyside Police will store the information collected on SharePoint until the child is aged 19 years, at which point it will be destroyed.
- Adopting a Right Care, Right Person approach, once the notification is received, any subsequent decision making and action is the responsibility of health care professionals.
- The information contained in the notification is limited to the identified unsafe sleep risk alone. It does not cover the reasons for the police attendance at an address. As the Safer Sleep app is essentially a signposting system for lower-level risk, it is not necessary to share more in-depth information.
- Should a higher level of risk exist, other safeguarding measures will be implemented. The notification will then undergo a standard risk assessment by the health visitor, prior to any visit to an address. This usually involves a phone call to the parent or guardian to arrange a mutually convenient time.

Testing the software

- Once the software was developed, it required testing to ensure there was a full feedback loop, from officers accessing the form to NHS Mersey Care receiving the automated email. To monitor incoming data, a Power BI dashboard was created by Merseyside Police in its Prevention Hub.
- The dashboard allows the force to identify trends such as repeat notifications and geographical or demographic hotspots of unsafe sleep practices. This allows responsible agencies to consider their approach to targeting support and education activity should this be required in particular regions or cohorts.

Safer Sleep app

After testing, the app was uploaded for access on all Merseyside Police systems, including handheld devices, laptops and desktop computers. Data captured in the app is directed by the requirements of NHS HVs. As any subsequent assessment and action is completed by the HVs, no additional data is required.

The questions contained are as follows.

1. Please select the area in which this notification is being made (this involves a tick box for each individual borough in Merseyside, ensuring the notification is sent to the correct NHS safeguarding team)
2. Child/young person’s name
3. Date of birth
4. Home address/current residence
5. Postcode
6. Contact number
7. Household language
8. GP details
9. Nursery/school/education provider (if relevant)
10. Reason for referral and advice given
11. Partner signposting

In comparison to the VPRF process, the form on the Safer Sleep app only takes 90 seconds to fill out. In cases where there are additional concerns, and potential serious harm, a VPRF1 can also be filled out alongside the safer sleep referral.

Barriers to implementation

The Safer Sleep initiative has not met with any resistance and those involved in implementation could not highlight any specific barriers to its rollout and delivery. The following points were highlighted as areas of potential difficulty for forces seeking to replicate the intervention.

The main barrier to implementation was the natural trepidation involved in implementing any new system. This was mitigated by the provision of a full police-specific training package about what unsafe sleep practices are, how to identify risk and how to access and complete the new app.

The Lullaby Trust has its own training packages available. However, it was felt that a more police-specific content and format was required to underline the distinction between health service responsibilities and the police. This training package was signed off as fit for purpose by NHS Safeguarding prior to being rolled out to police officers and staff.

There were some initial concerns from HVs regarding being sent into a potentially volatile or hazardous home environment after police attendance. Should these circumstances exist, other safeguarding measures would already be put in place to protect the child. Merseyside Police ran a basic awareness briefing, satisfying HVs as to the approach and their safety.

The Safer Sleep initiative hasn't yet shown a reduction in demand, which could result in less buy-in from certain stakeholders. Merseyside Police is keen to point out that the intervention was never about reducing demand but rather about prevention. However, a reduction in demand may be a positive additional benefit in the future.

Outcomes and impact

One of the key outcomes of the Safer Sleep intervention is that a gap in the existing VPRF process has been plugged. This has resulted in fewer missed opportunities to educate families and prevent SUDIs.

Safer Sleep is now embedded in Merseyside's training for new officers, raising awareness of unsafe sleep practices among officers, particularly those new to force. The new online training package has now been completed by over 1,700 officers and staff.

Merseyside Police is looking to further measure outcomes, including:

- the voice of the child
- an increase in trust across agencies, particularly the relationships between the NHS and local authorities

Measuring this impact will be supported by Liverpool John Moores University. It will complete a service evaluation study to measure the impact of the Safer Sleep system.

Feedback

Feedback available highlights the growing positive impact of the app.

‘It’s been great getting informed by police when families aren’t following our advice so we can offer more targeted support.' (HV)

‘I was worried this new process would be an increase in work but so far I’ve only found positives from contacting parents and ensuring they follow safe sleep advice.’ (HV)

‘As well as safe sleep, the notifications have helped me identify if a family may need additional HV support for other issues.’ (HV)

‘The police talked to me about where my baby was sleeping and then the health visitor came out and went over it again which was really helpful.’ (Parent)

Case studies

The following case studies were provided by NHS Mersey Care.

Case study A

Background	12-week-old baby living with parents. Police attended and identified unsafe sleep practices. Notification sent to health visitor (HV) team.
What was the problem?	Despite health visiting service having had two contacts with family and discussing safer sleep advice and completing safe sleep risk assessments at 12 days old and six weeks old, police attended and identified Child A at 12 weeks old was sleeping in a cot with excessive blankets and teddies.

What did we do?	Police that attended advised parents about the importance of a clear cot space. Police completed safer sleep notification to the HV team. HV arranged a visit to the family. HV discussed safer sleep. Parents believed risk was minimal due to large cot and small baby. HV reiterated risk of baby being smothered by teddies or blankets or becoming too hot if too many blankets were used. Safe sleep risk assessment completed again with parents.
What was the outcome?	Parents immediately removed excessive blankets and teddies. Risk of SUDI now reduced.
Feedback	Health visitor had advised mum she wanted to visit following identification of concern regarding unsafe sleep. Mum aware of police notification and understood reason for this. While at the visit, mum reported to HV why police had attended. Opportunity was given for HV to offer advice and support for this issue in addition to safer sleep advice.

Case study B

Background	Family not known to health visiting service
What was the problem?	Police attended address. While at address, discovered two adults and one year old co-sleeping. Police signposted family to other services and completed a safe sleep notification to the health visiting team.
What did we do?	Health visiting service completed a home visit and introduced the role of a HV. HV used interpreter on the phone during the visit. Discussed safer sleep and acknowledged police notification regarding co-sleeping. Mum aware of risk and reported would continue to co-sleep. HV offered advice following Lullaby Trust guidelines on how to co-sleep with less risk, for example where to position child, consideration of bedding and pillows and importance of supervision. HV also advised should never co-sleep when parents have been smoking, drinking alcohol or taking any drugs or medications that can make you sleepy. Parents confirmed they do not smoke or drink alcohol.
What was the outcome?	Parents were open and honest with services regarding their wish to continue to co-sleep. Services provided further advice about how to minimise risk of sudden infant death syndrome (SIDS) when co-sleeping.

Feedback	HV service would not have known about this family being in Liverpool if it hadn't been for police attendance. Mum reluctant at first to let HV into the property until interpreter was used and role of HV explained.

Case study C

Background	Family known to HV service. Children on child protection plan, with youngest being two years, three months old. Mum was pregnant and unborn baby was added to child protection plan.
What was the problem?	Police reported six children living in a three-bedroom house. There are at least two children per bed, including the referred child sleeping in the same bed as mother and youngest sibling. There are additional beds and cots, however, these are damaged, disused or overflowing with other items. Advice given at scene and aware of referral. This identified that mum was sharing her bed with a child under one year and a two year old which is not safe.
What did we do?	HV shared the police notification and concerns, along with their own concerns regarding safe sleep with the named social worker. HV and social worker had consistent conversations with mum regarding safe sleep and appropriate sleeping arrangements. Ongoing safeguarding procedures and visits took place. New beds and cots were provided by social care and eventually mum agreed to follow safe sleep guidelines.
What was the outcome?	The HV supported mum to transition both children to appropriate cot and bed. Mum is open and honest and reports she does occasionally still co-sleep but not with more than one child at a time.
Feedback	HV and social care providing ongoing support for family and trying to rehome. HV will continue to share safe sleep messages.

Longer term, an ambition of the Safer Sleep project is to use the new data to modify safe sleep messages and deliver bespoke messages to specific audiences. For instance, if a trend is identified in a specific geographical area or community via spoken language, options for community engagement can be explored. These can ensure the safer sleep message is delivered and understood beyond the information provided during antenatal and home visit appointments.

Statistical data will also be provided to child death overview panels and the National Child Mortality Database. They in turn can review and assess preventative data, rather than just that acquired following a SIDS incident.

Since the new system passed through the pilot phase into full Merseyside application, there has been growing interest from other NHS trusts, police forces and child safeguarding groups around the UK.

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