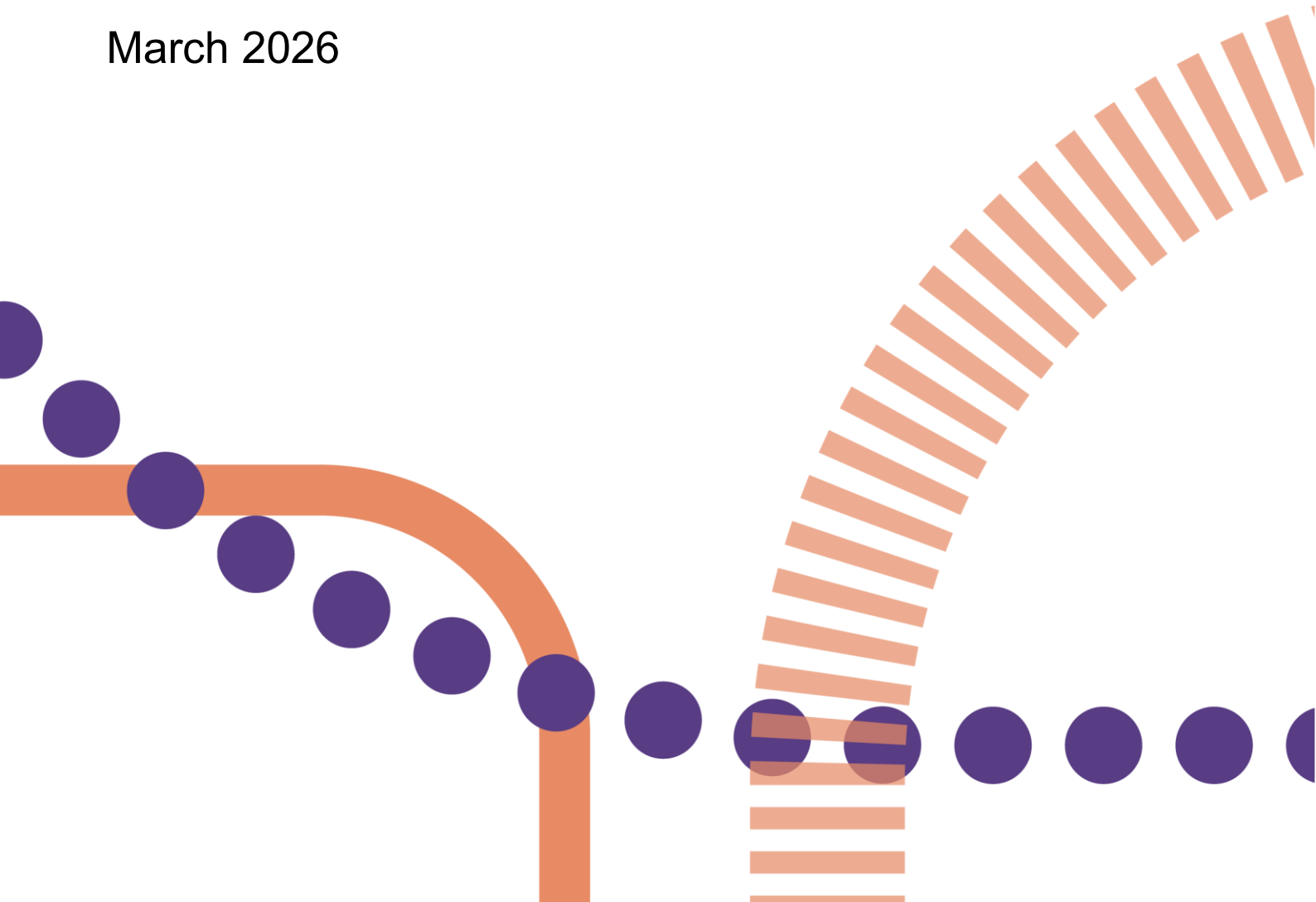
THE CHILD **SAFEGUARDING**
PRACTICE REVIEW PANEL

Safeguarding vulnerable under 1s

Co-sleeping: learning from serious child safeguarding incidents

March 2026



Introduction

The national Child Safeguarding Practice Review Panel published a national review about sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm in July 2020. The review found that a significant proportion of infant deaths could have been prevented through modifiable factors linked to safer sleep practice. It stated that underlying vulnerabilities, situational risks and out-of-routine circumstances heighten SUDI risk and may impede families' engagement with standard safer sleep messages. This briefing provides an overview of the risks associated with co-sleeping and SUDI, drawing on data evidence, national learning and best practice. It is intended as practical and reflective guidance for professionals across health, social care, housing, and community services.

Who is this document for?

Professionals working with infants and families across health visiting, midwifery, primary care, children's social care, early years, nurseries, childminders, housing, and other community services such as Family Hubs and Family First Partnership Programmes.

How to use this resource

This resource is designed to help practitioners and leaders to address SUDI reduction, complementing local policies and national guidance. The aim is to help local areas go beyond a siloed view of SUDI reduction, recognising it as part of broader risks and as a shared responsibility across all agencies.

This resource is not prescriptive. The Panel recognises the need for an individualised approach and a multi-agency delivery of bespoke, flexible support that is culturally sensitive, non-judgemental, and responsive to real-life pressures faced by families.

Why is it important for children and young people?

Understanding why families may not comply with co-sleeping advice is important because the practice can be unsafe, particularly for babies under one and those who may have other vulnerabilities. Practitioners need to be mindful where families are experiencing wider pressures, such as overcrowded homes, parental fatigue, parental substance use or chaotic and disrupted routines.

What is the evidence base?

The National Child Mortality Database Child Death Review Data Release summarises information about child deaths in England up to 31 March 2025 and the findings of reviews carried out by a Child Death Overview Panel on or before 31 March 2025.

The Panel's national review, Safeguarding children at risk from sudden unexpected infant death (2020) undertook a desktop analysis of 40 incidents of SUDI reported to the Panel.

- 21 of the infants were male (53%) and the majority (63%) were aged less than three months, with a peak at one month.

- 16 infants were reported to be of White British ethnicity, and 9 were from ethnic minority backgrounds. In the remaining 15 cases the infant's ethnicity was not stated.

- Of the 40 incidents:
    - 38 featured co-sleeping
    - 10 featured poor housing and overcrowding
    - 8 featured alcohol or drug misuse at the time of the last sleep

Key facts and figures

National Child Mortality Database:

- In the year ending 31 March 2025, there were 203 SUDI reported.
    - 190 recorded co sleeping as a contributory factor.
    - 188 infants were found to be in unsafe sleeping arrangements.
- Deaths of babies under 1 year of age accounted for 61% of all child deaths in the year ending 31 March 2025.
    - The death rate of infants who were resident in the most deprived neighbourhoods of England (5.3 per 1,000 infant population), remained more than twice that of infants resident in the least deprived neighbourhoods (2.2 per 1,000 infant population).
    - The estimated infant death rate continued to be highest for infants of black or black British ethnicity (7.0 per 1,000 live births); more than double the rate of infants of white ethnicity (3.0 per 1,000 live births).

Child Safeguarding Review Panel: annual report 2023 to 2024 included**:**

- 330 Serious Incident Notifications and rapid reviews submitted between March 2023 to April 2024.
    - 23% related to Sudden Unexpected Death in Infancy or Childhood (SUDI/SUDC).

Common issues

- **Advice may not always lead to action:** Despite evidence that clear guidance had been delivered by practitioners across all agencies, many families had not followed safer sleep recommendations. This may reflect practical challenges such as overcrowded housing, lack of suitable sleeping space, or financial constraints, rather than resistance to the advice. One rapid review offered evidence from a young parent engagement event that young mothers may often place their babies on cushions, over swaddle and/or co-sleep due to differing beliefs on the provision of loving care or to meet the emotional needs of the mother.

- **Changes in family circumstances:** Disrupted routines may influence decision-making in families which impact on sleep safety. Adherence to safer sleep guidance may vary whilst visiting friends or family, during periods of illness, when there is a new partner or during housing moves. Families that initially follow safer sleep guidance may find this hard to sustain without continued advice to address new situations.

- **Competing pressures and priorities:** In households dealing with stress, fatigue or crisis, safer sleep practices may be abandoned despite understanding the risks.

- **Cultural and personal beliefs:** For some families, co-sleeping is a culturally deeply rooted practice. If this context is not acknowledged, advice can seem irrelevant or impractical, reducing engagement and compliance.

- **Lack of ongoing support:** The national review strongly recommends that safer sleep needs to be a part of a broader multi-disciplinary approach to achieve health and wellbeing for a baby. In addition to routine health promotion messaging, discussions on broader wellbeing, including safer sleep and support with equipment, need to be ongoing at all visits.

- **Discrepancies between safeguarding partner knowledge:** In some partnerships, professional guidance in relation to SUDI and safer sleeping was limited to those working in health visiting and midwifery. Safeguarding partners should take a much broader multi-disciplinary and multi-agency approach.

Hallmarks of good practice

- **All professionals' responsibility:** Safer-sleep advice should be consistent, embedded and understood across all safeguarding partners to ensure a unified, comprehensive approach to risk reduction. It is particularly important that SUDI prevention is not treated in isolation from other aspects of infant safety, health and wellbeing.

- **Consistent multi-agency messaging**: Co-ordinated multi-agency guidance and training can help promote a shared understanding about a safer sleep environment and enables practitioners to reflect on their individual role in promoting safer sleep messages and recognising risk.

- **Adapt a coaching approach:** Embed safer sleep advice into family safeguarding plans by setting clear, practical goals (e.g. baby sleeps in a cot with no loose bedding). Use a coaching approach that combines empathy with challenge, exploring barriers

and problem-solving with families. Link safer sleep risks to wider safeguarding concerns and ensure multi-agency coordination for consistent messaging. Monitor progress through reviews and reflective supervision and advocate for training in motivational interviewing and cultural sensitivity to strengthen safer sleep conversations.

- **Personalised, culturally sensitive engagement:** Practitioners use a non-judgemental style, are attentive to cultural norms and family values, and co-produce safer-sleep plans that families can realistically implement.

- **Equitable access to practical resources:** Ensuring families, especially those with socioeconomic disadvantage, have safer sleep equipment (e.g. cot or Moses basket with a flat, firm mattress) together with evidence-based advice, removing barriers to safer behaviour.

- **Dynamic risk assessment:** Risk ('situational triggers' such as housing moves, staying in another home, illness, or fatigue) must be revisited regularly, and advice updated accordingly to respond to changes in the family's circumstances. Risk reviews can be informed by sharing information with other partners.

- **Regular and reinforced conversations:** Regular safer-sleep conversation can be built into routine interactions. Repetition across agencies helps parents hear and absorb messages over time, especially when routines are disrupted. The best results were found when strategies to reduce SUDI risk were embedded within usual service provision, beginning during the ante-natal period.

- **Consider the current circumstances.** Ask to see where the baby usually sleeps, where the baby slept last night, and what changes when families are tired, stressed or away from home.

- **Use changes in circumstances to revisit sleep arrangements.** Be alert to moments when risk increases, such as illness, housing moves, new relationships, substance use, overcrowding or periods of extreme fatigue.

- **Listening and building trust:** Practitioners should listen without judgement, recognise pressures and where co sleeping is occurring, explore why this is happening. Relationships with families are built over time and are enhanced by practical, achievable suggestions rather than repeating advice. Being honest about risk, while offering support and revisiting plans as circumstances change, helps families stay engaged.

- **Skilled, confident workforce:** Training empowers all professionals to hold potentially sensitive conversations, understand cultural contexts, and provide evidence-based, empathetic guidance.

- **Leadership and local accountability:** Safeguarding partnerships should take collective ownership, monitor implementation, and ensure strategy, commissioning, and workforce planning reflect local needs and include safer sleep as a priority.

Reflective questions and discussion points

- How practical and achievable is safer sleep advice for this family's circumstances?
- Have I seen and do I understand where the baby is sleeping on a regular basis?
- If safer sleep advice is not being followed, do I know why? Is this due to space or financial constraints, cultural norms, fatigue or other factors? What realistic alternatives can I offer?
- Do I revisit safer sleep guidance at key points (e.g. illness, new partner, housing changes)?
- How do I ensure my conversations are non-judgemental and culturally respectful, encouraging honest disclosure about co-sleeping?
- Am I using professional curiosity to understand the family's routines and pressures, rather than assuming compliance?
- Do I share updates and risks promptly with other agencies to maintain a coordinated response?

Questions for leaders

- Do our partnership plans prioritise SUDI prevention and clearly set out how we will resource safer sleep work across all agencies?
- Are we commissioning practical support (e.g. cots, targeted home visiting, peer educators) alongside advice, so families with additional vulnerabilities can implement safer sleep?
- Have we considered using the Child Safeguarding Practice Review Panel national review "prevent & protect" practice model with named owners for each component?
- Does our multi-agency training equip all practitioners to engage families in non-judgemental, culturally aware conversations about co-sleeping and how to re-assess situational risks at each contact?
- Do supervision frameworks prompt staff to flex advice into practical plans (e.g., preparing the sleep space before feeds; alternatives on nights of extreme fatigue)?

Case study

The example below from the national review illustrates SUDI in a family with recognised risks.

A woman whose previous children had been removed due to neglect booked her pregnancy late. This prompted midwives to make a referral to children's social care. The woman engaged well with the pre-birth assessment process. She disclosed domestic violence by the father, stated that the relationship had ended and he was no longer resident in the home. She also disclosed cannabis use and agreed to attend a drug intervention programme. Following the baby's birth, a child in need plan was initiated and the baby was discharged into her care. When the health visitor undertook a home visit, the house was found to be cluttered but in reasonable condition. Safer sleep advice was given and appeared to be well received. Following an evening of cannabis use with the baby's father, the mother laid the now two-month old baby to sleep in bed with her and awoke the following morning to find her baby dead.

Learning points:

- The circumstances weren't explored. For example, asking to view where the baby slept.
- There was no offer of access to practical resources, such as providing a moses basket.
- The previous history of agency involvement was not taken into consideration.
- Safer sleep advice was given but did not include practical steps or a plan.
- Contextual risks, such as the father's history of domestic violence and the mother's history of neglect and cannabis use, were not fully considered.

Where can I find out more?

Find more information on the Panel's new learning hubwww.childsafeguarding.independent-panel.uk, where you can access videos, webinars, podcasts and other content, including the full report: Out of Routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm.

Other useful resources include:

- Safer sleep overview | The Lullaby Trust
- Co-sleeping | The Lullaby Trust
- Healthy child programme - GOV.UK
- Vulnerability in childhood: a public health informed approach - GOV.UK