South Australian Safe Infant Sleeping Standards
Policy Directive

Version No.: V2.1
Approval date: 16/10/18

Best Practice Indicators for SA Health, Department for Child Protection
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1. Policy Statement

The sudden and unexpected death of infants during sleep has reduced significantly since a public health campaign about safe sleeping for infants was conducted in the 1990s. However, the sudden and unexpected death of infants during sleep remains a leading cause of preventable death for infants between one month and one year of age.

The six standards contained in this policy document provide clarity and direction for staff and volunteers working with parents/caregivers and families with infants under 12 months of age. This document is intended as a practical resource and outlines essential safe infant sleeping practices and environments alongside the respective challenges they pose for parents/caregivers and staff. The Standards are informed by the available evidence about risk factors in the infant sleeping environment as well as current professional practice and consumer needs and apply to all families with infants from birth through to 12 months of age.

2. Roles and Responsibilities

Staff and volunteers who provide support and advice to parents/caregivers who are able to assess an infant’s care and sleep environment, identify any of the factors associated with sudden unexpected infant death in those environments and take appropriate action to reduce the chances of this happening.

These Standards will do this by helping staff and volunteers to:

- Assess the risk factors in the infant’s care and sleep environments that are associated with sudden and unexpected infant death and talk with parents/caregivers about those risks
- Promote and model to families evidence-based safe infant care and sleep environments
- Provide parents/caregivers and families with relevant information about the things they can do to make their infant’s care and sleep environment as safe as possible and the reasons why it is important to do these things
- Assist parents/caregivers and families to access relevant services, supports or referrals, or if necessary engage relevant services, supports or referral on their behalf
- Document discussions and actions taken with the family in the client record.

Parents/caregivers will make their own decisions about where and how they sleep their infant. Staff and volunteers are responsible for ensuring that parents/caregivers are provided with all the information they need to make a choice that minimises the chances that their infant will die suddenly and unexpectedly.

The South Australian position is to provide clear messages to all parents/caregivers, regardless of their social and life circumstances, in ways that they can understand, and in ways that helps them to make informed decisions. This includes:

- known best practices in relation to safe infant sleeping;
- reasons why these practices are safest; and
- the dangers and risks of practices which differ from those being promoted.
This approach encourages having conversations with parents/caregivers about risks. If a parent or caregiver does not appear to understand or have the capacity to make changes, this should be a case for heightened concern and other ways of supporting those parents and or carers to provide a safe infant care and sleep environment, should be actively explored (e.g. financial, cultural).

Providing support and appropriate advice to parents and carers can help to reduce the chances that their infant will die suddenly and unexpectedly. Such support can come from agencies such as, SIDS and Kids, Kidsafe SA, Department for Child Protection, Disability SA, mental health services, child care workers, health or welfare agencies and also from extended family, general practitioners and child and family health nurses.

3. Policy Requirements

3.1 Scope
Staff and volunteers who provide support and advice to parents / caregivers with infants under 12 months of age.

3.2 Principles
- Taking a preventative, proactive and participatory approach to infant health
- Valuing and embracing the opinions and views of parents, guardians or carers
- Being sensitive to and focused on the protection of infants
- Taking action to protect infants from unsafe practices
- Providing parents, guardians or carers with evidence of infant safe sleeping environments and practices
- Having culturally inclusive practices which nurture and affirm parents, guardians or carers in their role.
- Having information that uses clear, straightforward, and inclusive language appropriate for the client, that is available in other languages and modes of communication.

3.3 Background
The SA Safe Infant Sleeping Standards were developed by a core group of experts from Government and non-Government sectors in South Australia under the direction of the South Australian Safe Sleeping Advisory Committee. They were the result of extensive consultations and conversations, not only with members of the Committee, but also with local and interstate experts outside the Committee including consumers, retailers, staff within SA Health, Families SA, Disability SA, Department for Education and Children’s Services (DECS) Early Childhood, Queensland Health and the Victorian Child Safety Commissioner.

The Standards were written to guide staff and increase family and community awareness of the key infant care practices associated with reducing the risk of infants dying while asleep. The Standards provide information consistent with the safe sleeping recommendations being promoted in many parts of the world and were informed by current Australian and international research.

The Committee took into account all available evidence and arrived at an approach which it believed best supported the interests of public health. The safety of infants was given the highest priority in formulating these recommendations.
The standards have now been reviewed by a workgroup facilitated by the SA Child Health Clinical Network (CHCN) bringing together former members of the Advisory Committee, SA Health and other relevant stakeholders for the purpose of updating the Policy Directive to incorporate new evidence, coroners’ recommendations and current best practice.

### 3.4 Incidence

In Australia, infant deaths attributed to SIDS have fallen substantially during the last 20 years\(^2\). Evidence suggests that the marked reduction in SIDS can be attributed to the Australian public health campaigns which promoted safe sleeping practices, particularly advice to parents/caregivers to place infants on their back to sleep\(^5\).

The number of infant deaths attributed to SIDS has also fallen in South Australia during the past decades; from 2.1 per 1,000 live births in 1986 to 0.3 per 1000 live births in 2013\(^5\). This is mostly attributable to the success of the SIDS and Kids Reducing the Risk of SIDS Campaign, but also to changing trends in classification. However, annually over the past few years there have been approximately 10 sudden unexpected deaths in infancy associated with unsafe sleeping environments (Figure 1). Tragic in themselves, each of these deaths prompts us to consider how we can help parents/caregivers to provide the safest possible care and sleep environment for their infant.

*Figure 1: Infant death rates per 1,000 live birth for three subcategories of SUDI (SIDS, accidental asphyxia and undetermined cause of death), South Australia 2003-2013*

3.5 Risk factors for SUDI, SIDS and fatal sleeping incidents

In research studies undertaken about SUDI, SIDS and fatal sleeping incidents, a significant number of factors have been identified that have been associated with sudden unexpected infant death. The level of risk increases significantly when several of these factors are clustered in the infant’s care or sleep environment \(^6\)\(^\text{-11}\). Some of these factors

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South Australian Safe Infant Sleeping Standards Policy Directive

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are about infants themselves, some are about their environment and some are about parents/caregivers and their ability to provide for an infant.

Some of the factors associated with infants and sudden unexpected death include:

- Infants who are born prematurely (<37 weeks)
- Infants of low birth weight (<2,500g)
- Multiple births
- Male and first born infants
- Infants who have problems after birth including a history of minor viral respiratory infections and/or gastrointestinal illness.

Factors about the environment, parents/caregivers and families and their ability to provide for an infant, that have been associated with sudden unexpected death include:

- Young parental age
- Mental health problems or cognitive difficulties experienced by parents/caregivers
- Domestic violence occurring in households
- Transient lifestyle, with lack of access to a stable home.

There were 55 infants born in South Australia between 2007 and 2012 that died suddenly and unexpectedly at a time when they were expected to be sleeping. All of these infants were over 28 days old. A review of the care and sleep environment of these infants confirmed some of the well-known factors that can be modified or changed in ways that will reduce the chances of sudden and unexpected death, including:

- Unsafe cot and bedding
- Parental smoking (before and after birth)
- Use of alcohol and other drugs, including prescription medication, that makes the parent/caregiver drowsy and less responsive to infant cues
- Infants in a prone (face down, tummy) sleeping position
- Infants and parents/caregivers sharing the same sleep surface (such as bed, couch, sofa, chair etc.).

In addition, there are other factors that have been shown to reduce the chance that an infant will die suddenly and unexpectedly. These include:

- Sleeping an infant in the same room as the parents/caregiver
- Ensuring that an infant is fully immunised
- Using a pacifier (once breastfeeding has been established)
- Breastfeeding.

3.6 The South Australian approach to sharing a sleep surface with infants

The issue of an infant sharing the same sleep surface with an adult or child is complex. Unfortunately there is currently no evidence available that clearly shows that parents/caregivers can safely share a sleep surface with an infant whether this is by modifying the bedding or their own behaviour.
Earlier studies suggested that the risk of SIDS was only increased when infants shared a sleep surface and their parents smoked, used sedating drugs, were fatigued, the infant was born prematurely or low birthweight, or was not being breastfed.

The National Institute for Health and Care Excellence (NICE) recently reviewed the research about the risks of infants sharing a sleep surface and concluded that:

“there is an association between co-sleeping and SIDS, that the association between co-sleeping and SIDS is likely to be greater when they or their partner smokes, and that the association between co-sleeping and SIDS may be greater with parental or carer recent alcohol consumption, drug use or the infant is of low birthweight or premature”13.

These findings were incorporated in NICE’s Addendum to Clinical Guideline 37, Postnatal Care14. In this report the term ‘co-sleeping’ was defined as sharing of a bed, or other sleep surface, such as a sofa or a chair to sleep.

Other research has more definitively demonstrated that sharing a sleep surface can pose a risk to all infants regardless of these additional risk factors. For example the recently published Literature Review and Recommendations for Safe Infant Sleeping15 (Monash University) have sought to identify the risks associated with infants sharing a sleep surface. This research concluded that:

“sharing a sleep surface increases the risk for SIDS for all infants under three months of age. The risk of SIDS when sharing a sleep surface is further increased with maternal smoking, alcohol or drug use and sharing a sofa or couch with an infant significantly increases the risk for SIDS”16.

Based on these studies, the SA Health Standard considers that parents need to be informed about the risk factors that have been frequently associated with increasing the likelihood of an infant dying suddenly and unexpectedly when they are sharing a sleep surface. Some of these factors are about infants themselves, some are about their environment, and some are about parents/caregivers and their ability to provide for an infant:

- Sharing a couch or sofa carries the highest risk of fatal sleeping incidents17.
- Adult sleeping environments contain hazards that can be fatal for infants18. These hazards include overlaying of the infant by another individual; entrapment or wedging between the mattress and another object such as a wall; head entrapment in bed railings, and suffocation from pillows and blankets19.
- Infants most at risk of fatal sleep incidents whilst sharing a sleep surface are those who are born preterm or small for gestational age20.
- Infants younger than three months of age are at greater risk of fatal sleep incidents when sharing a sleep surface21,22.
- If a parent/carer smokes, then the risk of a fatal sleep incident is highest for infants, particularly for infants less than 12 weeks old23.
- If a parent/carer has used drugs/alcohol then the risk is likely to be greater if the infant is of low birthweight or premature24.
- Lastly, when there is more than one risk factor – the chances of an infant dying suddenly and unexpectedly are even higher25.

In these Standards, the term ‘bed sharing’ has been used to describe taking a baby to bed for feeding, cuddling and playing, when there is no intention of sleeping with the infant. There appears to be no increased risk of a fatal sleep incident if parents/caregivers return the infant to its own safe sleeping surface prior to the parent or carer going to sleep.
Bed-sharing and room-sharing

The Standards promote the benefits of room sharing (placing an infant for sleep in an Australian Standards compliant cot in the same room as the parents/caregiver) for the first six to twelve months as this is known to reduce the risk of SIDS\(^{26,27}\). Several studies have demonstrated that infants who sleep in close proximity to their mothers also have better outcomes relating to successful initiation and duration of breastfeeding\(^{28}\).

### 3.7 About the standards of practice

These Standards apply:

- To all SA Health, Families SA, and Department for Education and Child Development Early Childhood Services staff, carers, and volunteers whose work brings them in contact with parents/caregivers and families with infants under 12 months of age.
- To all settings across clinical, acute care and the community.
- In all circumstances, unless medically indicated reasons state otherwise.

These Standards aim:

- To ensure staff and volunteers in all facilities both public and private sectors (i.e. antenatal, birthing, postnatal, paediatric, child health, childcare, community and general practice settings) promote and model safe infant care practices and environments consistent with the Standards.
- To ensure staff and volunteers provide parents/caregivers with consistent and accurate information that take into consideration the needs of the infant and the family and the opportunity to observe recommended safe sleeping practices.
- To support ongoing training and/or professional development activities that builds the capacity of staff and volunteers to model and promote safe sleeping best-practice.

These Standards support staff and volunteers to effectively promote and model the six safe infant care practices which ensure a safe sleeping environment. It is expected that all staff and volunteers will comply with these Standards unless medically indicated reasons state otherwise.

**Standard 1**

All staff will place well infants under 12 months on their back to sleep from birth, never on their front (tummy) or side, unless there are medically indicated reasons.

**Standard 2**

All staff will be fully informed about the risks of sharing the same sleep surface with an infant and promote the placing of infants for sleep in an Australian Standards compliant cot (AS/NZS 2172)\(^{29}\) in the same room as the parents for the first six to 12 months.

**Standard 3**

All staff will consider the social, cultural and life circumstances of each family when promoting safe sleeping practices and ensure the information is provided in ways that are culturally accessible and can be easily understood by that family.

**Standard 4**
All staff will ensure that expectant and new parents are made aware of the strong association between smoking and the increased risk of SIDS and are supported and referred to smoking cessation or reduction programs.

**Standard 5**
All staff will provide parents, caregivers and families, with accurate information about a safe cot, with a safe mattress, safe bedding and in a safe environment.

**Standard 6**
All staff will ensure that expectant and new parents are made aware of the benefits of breastfeeding as a protective factor in reducing the risk of SIDS and are later given support to breastfeed.

This document lists Standards common to all staff and volunteers. Additional indicators apply to SA Health, Families SA and DECD Early Childhood Services staff. See Appendices 1, 2 and 3 for those additional indicators relevant to your organisation.

### 3.8 The six safe infant care practices

The following key infant care practices ensure a safe sleeping environment for infants up to 12 months of age:

1. Sleep infants on their back from birth for every sleep period (night and day), never on their front (tummy) or side.

2. Sleep infants with:
   - feet at the foot of the cot,
   - appropriate bedclothes or sleeping bag which are the correct weight for the season to provide adequate warmth whilst avoiding overheating,
   - head and face uncovered,
   - bedclothes tucked in securely so bedding is not loose, or in a sleeping bag which is the correct size for the infant with fitted neck and arm holes and no hood, and
   - without quilts, doonas, duvets, pillows, cot bumpers, sheep skins, soft toys or any other soft item which could pose an asphyxiation risk.

3. Avoid exposing babies to tobacco smoke before and after birth.

4. Sleep baby in their own cot in the same room as the parents for the first six to 12 months.

5. Provide a safe sleeping place night and day in a cot that is compliant with the Australian Standards for Household Cots (AS/NZS 2172)\(^{30}\) and positioned away from blind cords and other hazards.

6. Breast feed baby if you can.
Six ways to sleep baby safely and reduce the risk of sudden unexpected death in infancy:

- Sleep baby on back
- Keep head and face uncovered
- Keep baby smoke free before and after birth
- Safe sleeping environment night and day
- Sleep baby in safe cot in parents’ room
- Breastfeed baby if you can

Image courtesy of SIDS and Kids
It is always important to consider an infant or child’s ability to move, lift and turn their head to breathe when choosing the most appropriate sleeping situation, cot, bed, bedding and temperature control.

Although the current definitions and classifications presented in this document refer to an age limit of up to 12 months and relate to the immediate sleeping environment (e.g. sleep positioning, cot), other items in or around the sleeping environment, such as blind cords or electrical cords, can pose a risk of strangulation for children of any age. These and other risks become more hazardous as infants become more mobile and capable of exploring their environment. For this reason it is important that parents continue to remain alert to risks in the sleeping environment throughout their child’s developmental stages.

Parents and carers of children with identified developmental delay or special needs are encouraged to consult with their child health specialist (i.e. doctor, nurse, allied health worker) regarding the safest sleep practices for their child. Staff should consider referring parents/caregivers to their child health specialist (i.e. doctor/nurse/allied health worker) for further information regarding infant safety issues as well as information in relation to the infant’s overall health, development and wellbeing.

The safe infant care practices referred to in these Standards apply in all circumstances unless medically indicated reasons dictate otherwise. These Standards do not replace specific agency guidelines, protocols or procedures.

4. Implementation and Monitoring
SA Health Local Health Networks continue to undertake Client Case Record Audits

5. National Safety and Quality Health Service Standards

The National Standards below will be implemented from 1 January 2019.

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6. Definitions

In the context of this document:

- The term ‘adult sharing the same sleep surface with an infant’ is used in place of the term ‘co sleeping’ to encompass all surfaces that might be shared including a bed, couch, chair, sofa etc.

- the definition of sudden unexpected death in infancy (SUDI) used is based on the definition proposed by Fleming and others31.

  This definition includes infants under one year of age whose deaths:
  - were unexpected and unexplained at autopsy;
  - occurred in the course of an acute illness that was not recognised by parents/carers and/or health professionals as potentially life-threatening;
  - arose from a pre-existing condition that had not been previously recognised by health professionals; or
  - resulted from any form of accident, trauma or poisoning.

sudden unexpected death in infancy could be described as an umbrella term with Sudden Infant Death Syndrome (SIDS) a subset of SUDI. The definition for SIDS currently accepted in Australia and by many experts internationally, is the San Diego definition proposed by Krous and others32.

‘the sudden and unexpected death of an infant under one year of age, with onset of the lethal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including performance of a complete autopsy and review of the circumstances of death and the clinical history’.

- The current definition of SIDS has become more stringent, such that some deaths which were attributed to SIDS in earlier years would now be classified as SUDIs in the ‘unexplained’ group.

SUDIs fall into one of two categories:
- explained deaths of infants which incorporate criteria 2 to 4 of the above definition; or
- unexplained deaths of infants accounted for by criteria 1 and incorporating the San Diego definition of SIDS proposed by Krous and others

7. Associated Policy Directives / Policy Guidelines and resources

All references, Resources and Related Documents are provided throughout the Standards themselves.
8. Document Ownership & History

Document developed by: Child Health Strategy, Women’s and Children’s Health Network
File / Objective No.: eA891217 – DHA2015-06350/1
Next review due: 31/07/2021
Policy history:
Is this a new policy? N
Does this policy amend or update an existing policy version? Y
If so, which version? V2.0
Does this policy replace another policy with a different title? N
If so, which policy (title)?

ISBN No.: 978-1-76083-079-3

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<th>Version</th>
<th>Who approved New / Revised Version</th>
<th>Reason for Change</th>
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<tr>
<td>16/10/18</td>
<td>V2.1</td>
<td>Interim Director Health Informatics, Performance, Planning &amp; Outcomes</td>
<td>Minor changes in line with Legislation</td>
</tr>
<tr>
<td>03/10/16</td>
<td>V2.0</td>
<td>Approved at Portfolio Executive</td>
<td>Formally reviewed in line with 1-5 year scheduled timeline for review. Section 5.4 and references updated to reflect current research and populated into policy template.</td>
</tr>
<tr>
<td>14/02/11</td>
<td>V1.0</td>
<td>Approved at Portfolio Executive</td>
<td>Original Portfolio Executive approved version.</td>
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Standards

South Australian
Safe Infant Sleeping Standards
9. South Australian Safe Infant Sleeping Standards

Standard 1

All staff will place well infants under 12 months on their back to sleep from birth, never on the front (tummy) or side, unless there are medically indicated reasons.

Indicators of best practice

To meet this Standard, all workers must be able to:

1. Describe to parents with infants under 12 months of age how to place the infant on their back from birth for every sleep period (night and day):
   - with feet at the foot of the cot,
   - with appropriate bedclothes or sleeping bag which are the correct weight for the season to provide adequate warmth whilst avoiding overheating,
   - with head and face uncovered,
   - with bedclothes tucked in securely so bedding is not loose, or in a sleeping bag which is the correct size for the infant with fitted neck and arm holes and no hood,
   - without quilts, doonas, duvets, pillows, cot bumpers, sheep skins, soft toys or any other soft item which could pose an asphyxiation risk,
   - provide parents and caregivers with evidence about the risks associated with side and front (tummy) sleep positions (illustrated below).

2. Provide parents and caregivers with advice about the importance of a firm sleeping surface (mattress) and offer to view.

3. Recognise when lack of appropriate sleep and settling strategies are contributing to unsafe sleeping practices and make relevant referrals based on the specific needs of the infant and the family circumstances.

4. Explain to parents and caregivers the importance of supervised tummy time when the infant is awake (i.e. to strengthen infant neck muscles and prevent a ‘flat head’).

5. Explain to parents and caregivers the dangers of positional aids, devices and rolls which are marketed to maintain infants in certain sleep positions in the sleep environment (such devices could pose an asphyxiation risk).

6. Recognise when referrals, supports and information are necessary to better support the parent or caregiver to provide a safe sleeping environment for their infant (see pages 32–34).

Image courtesy of SIDS and Kids ACT
Indicators of best practice

To meet this Standard, all workers must be able to:

1. Explain the risk factors (see page 6) which contribute to the deaths of infants, particularly the risks of sharing the same sleep surface with infants.
2. Describe to parents of infants aged under 12 months the benefits of room sharing (see below).
3. Describe to parents the risks of sharing the same sleep surface with infants whilst still encouraging breastfeeding, bonding and closeness before returning the infant to its own cot beside the bed.

   If parents choose to share a sleep surface with a baby, use of the SIDS and Kids Information Statement on ‘Sharing a sleep surface with a baby’ may be appropriate.

   Review of this article highlights that caution be taken when considering the benefit listed as “Higher Self-esteem, better social skills and emotional outcomes as young people and adults”. None of the articles show that bed or room sharing causes improvements in the above area, only that it does not cause problems.

4. Work in partnership with parents and caregivers to develop settling and sleep strategies which work best for the family or ensure a referral is made to Child and Family Health staff for assistance with this. Suggested strategies must take into account the family’s social, cultural and life circumstances.

5. Link families with appropriate supports and resources, making referrals as necessary and documenting these in the client record (see pages 34–38).

These are definitions of the terms used in this Standard:

**Room sharing (RECOMMENDED)**

Room sharing is defined as an infant sleeping in an Australian Standards compliant cot (AS/NZS 2172) in the same room as their parents. This is recommended for the first six to 12 months of life.

‘Bed sharing’ is defined as taking a baby to bed for feeding, cuddling and playing, when there is no intention of sleeping with the infant. There appears to be no increased risk of a fatal sleep incident if parents/caregivers return the infant to its own safe sleeping surface prior to the parent or carer going to sleep.
Sharing the same sleep surface with infants
(NOT RECOMMENDED)

Sharing the same sleep surface with infants commonly referred to as ‘co-sleeping’ refers to mothers/partners (or any other person) sleeping on any surface (bed, sofa, couch, chair or mattress but not limited to) with an infant, whether with the intention to fall asleep or not.

*Please note that these definitions differ slightly from those proposed by UNICEF because of the evidence regarding the protective effect of room sharing and because in the SA context we wish to make clear distinctions between sharing the same sleep surface and sharing the bed when awake with an infant to feed or cuddle (bed sharing).*

**Standard 3**

All staff will consider the social, cultural and life circumstances of each family when promoting safe sleeping practices and ensure that information is provided in ways that are culturally accessible and can be easily understood by that family.

**Indicators of best practice**

To meet this Standard, all workers must be able to:

1. Demonstrate they are able to promote the safe infant care practices recommended by SIDS and Kids in the format most appropriate for the individual family and caregiver.

2. Facilitate access to further evidence-based culturally appropriate information, services and resources related to safe infant sleeping particularly for ‘high needs’ and vulnerable clients, including pregnant women, young parents and families from Aboriginal and Torres Strait Islander and other diverse cultural communities.

3. Work in partnership with families to identify any specific resources, information and services that may be required to meet the unique needs of the infant or the family circumstances.

4. Make referrals as appropriate, particularly where there is reason to believe the parent/caregiver is unable to understand the risks inherent in the sleep environment (e.g. due to language difficulties, intellectual disability or mental health issues).

5. When necessary, engage culturally appropriate supports: such as a person or service that has credibility with the family and is able to translate or convey the evidence-based safe infant care practices in the language or manner that is most suitable for that family (see pages 39–41).

6. Document in the client record any risks identified and referrals made.

The Translating and Interpreting Service provides professional translating services 24 hours a day, 7 days a week – phone 131 450 and quote your service’s client number.

See page 41 for services available to Aboriginal families.
Standard 4

All staff will ensure that expectant and new parents are made aware of the strong association between smoking and the increased risk of fatal infant sleep incidents and that they are supported and referred to smoking cessation or reduction programs.

Indicators of best practice

To meet this Standard, all workers must be able to:

1. Explain to expectant and new parents the harmful effects to the infant of smoking during pregnancy and second-hand smoke after birth.

2. Describe to families the importance of ensuring a smoke-free zone around pregnant women, infants and children to avoid them being exposed to tobacco smoke before and after birth. This includes the parent’s bedroom when room sharing occurs.

3. Work in partnership with individuals to increase smoking disclosure and support them to stop or reduce smoking (e.g. the 5A’s approach: Ask, Advise, Assess, Assist, Arrange).

4. Provide pregnant women who smoke with Quit SA resources and referral information as appropriate to assist them to cease or reduce smoking (see pages 42 and 43).

All community facilities will promote smoke-free displays and smoking cessation resources (e.g. antenatal and maternity outpatient clinics, postnatal wards, neonatal units, child care centres, etc.).

All agencies will ensure educational messages relating to smoking are available to secondary care providers including day care and child care providers, grandparents, foster parents and babysitters.

Image courtesy of SIDS and Kids ACT
Standard 5

All staff will provide families and caregivers with accurate information about a safe cot, with a safe mattress, safe bedding and in a safe environment.

Indicators of best practice

To meet this Standard, all workers must be able to:

1. Describe the dangers associated with a cot that doesn’t comply with the Australian Standards for Household Cots (AS/NZS 2172) or is in poor condition, broken or damaged with missing slats. This includes:
   - where the spacing between the bars may be too wide and trap a child’s head or too narrow and trap a child’s arms or legs,
   - where the corner posts of the cot may be higher than the sides and ends creating a strangulation hazard if clothes get caught on any corner post,
   - when the mattress does not fit snugly to within 20mm of the sides and ends, and when pillows, toys and other items are not removed to prevent asphyxiation.

2. Explain, particularly to expectant parents and families with young infants, the Australian Standards for Household Cots and the importance of positioning the cot away from blind cords and other hazards.

3. Provide information about safe infant care practices and safe sleeping environments to parents and caregivers of infants under 12 months.

4. Consistently model safe sleeping environments in community settings and offer to view environment, bed and bedding.

5. Link families with appropriate supports and resources – make referrals as necessary and document this in client records (see pages 44 and 45).
Household cots

The following Information is courtesy of SIDS and Kids: Frequently Asked Questions ‘What to look for in Household Cots’.

A safe cot is one that meets the Australian Standard for cots. All new and second-hand cots sold in Australia must meet the Australian Standard for Cots (AS 2172)\textsuperscript{20} and will carry a label to say so. The standard includes:

- the mattress must be firm, flat, in good condition and fit snugly to within 20mm of sides and ends
- with the mattress base set in the lower position, the cot sides or end need to be at least 500mm higher than the mattress
- the spacing between the bars or panels in the cot sides and ends needs to be between 50mm and 95mm—gaps wider than 95mm can trap a child’s head. If the bars or panels are made from flexible material, the maximum spacing between the bars or panels should be less than 95mm
- no small holes or openings between 5mm and 12mm wide in which small fingers can be caught
- no spaces between 30mm and 50mm that could trap a child’s arms or legs
- no fittings (including bolts, knobs and corner posts) that might catch onto a child’s clothing and cause distress or strangulation.

Old or second hand cots may not meet the current Australian standards and may be dangerous for the following reasons:

- Wobbly or broken parts that make the cot weak
- Gaps where an infant or child may get caught
- Knobs, corner posts or exposed bolts that can hook onto an infant or child’s clothing and tighten around the neck
- Sides that are too low and can be climbed over by active children
- Sharp catches or holes in the wood that can hurt curious little fingers
- Paint that might contain poisonous lead.

A helpful resource that has been developed for consumers by the ACCC called ‘Find out More: Keeping Baby Safe - a guide to infant and nursery products’ that provides advice to parents/caregivers on what to look for when purchasing items for an infant’s nursery.

It is available on their website www.accc.gov.au.
Standard 6

All staff will ensure that expectant and new parents are made aware of the benefits of breastfeeding as a protective factor in reducing the risk of SIDS and are later given support to breastfeed.

Indicators of best practice

To meet this Standard, all workers must be able to:

1. Explain to expectant and new parents the benefits of initiating and establishing breastfeeding as a preferred feeding option for their infant after birth.

2. Provide pregnant women with information about breastfeeding and support services post birth to assist them to make informed choices re methods of feeding.

3. Work in partnership with individuals to increase breast feeding uptake and support them to initiate breastfeeding as soon after birth as possible.

4. Describe to families the benefits of breastfeeding on the infant and mother attachment relationship.

5. Explain to expectant and new mothers that several studies have demonstrated that infants who sleep in close proximity to their mothers have better outcomes relating to successful initiation and duration of breastfeeding.

All birthing hospitals and community facilities will promote breastfeeding and display information and resources to support expectant mothers and new mothers decision to initiate and establish breastfeeding including information on access to breastfeeding support (e.g. antenatal and maternity outpatient clinics, postnatal wards, neonatal units, child care centres, etc.).

All agencies will ensure educational messages relating to breastfeeding as a preferred feeding option for infants is available to secondary care providers including day care and child care providers, grandparents, foster parents and babysitters.
Appendices

Appendix 1:
Additional best practice indicators
specific to SA Health staff and volunteers

Appendix 2:
Additional best practice indicators
specific to Department for Child Protection staff and volunteers

Appendix 3:
Additional best practice indicators
specific to Department of Education
– Early Childhood Services staff and volunteers

Appendix 4:
Details of the original committee who developed the Standards
Appendix 1

**Additional best practice indicators specific to SA Health staff and volunteers**

**Standard 1:** All staff will place well infants under 12 months on their back to sleep from birth, never on the front (tummy) or side, unless there are medically indicated reasons.

To meet this Standard, all health workers must be able to:

1. Provide parents and caregivers with information on how to position infants safely in the cot and an explanation of the risks associated with side and front (tummy) positioning.
2. Provide sleep and settling strategies that support parents and caregivers in ways that take into account the specific needs of the infant and the family circumstances.
3. Demonstrate the practice of placing all infants, including those with gastroesophageal reflux, on their back to sleep on a firm, flat mattress that is not elevated.
4. Provide parents and caregivers with strategies to manage gastroesophageal reflux effectively without placing the infant at risk.
5. Demonstrate the practice in neonatal units of placing premature and low birth weight infants on their backs as soon as their oxygen requirements allow and well before discharge.
6. Demonstrate, where a medical directive exists that requires the infant is not placed on their back to sleep in a health facility, that information is provided to parents or caregivers prior to discharge about the importance of placing baby on their back once home.

**Standard 2:** All staff will be fully informed about the risks of sharing the same sleep surface with an infant and promote the placing of infants for sleep in an Australian Standards (AS/NZS 2172) compliant cot in the same room as the parents for the first six to 12 months.

To meet this Standard, all health workers must be able to:

1. Work in partnership with parents and caregivers to identify settling and sleep strategies which take into account the families’ social, cultural and life circumstances.
2. Demonstrate that the birthing and post-natal facilities where they work model the placing of cots by the mother’s bed (away from blind cords) and promote the return of infants to their cot after feeding and before parents fall asleep.
3. Demonstrate that discharge planning, in particular from postnatal or neonatal care units, takes into account risk factors (infant characteristics, parental capacity and environment) and ensures accurate information is provided and appropriate referrals are made in response to these.
4. Demonstrate that discharge planning, in particular from postnatal or neonatal care units, includes information for parents about the risks of sharing the same sleep surface with infants and the benefits of room sharing.
Standard 3: All staff will consider the social, cultural and life circumstances of each family when promoting safe sleeping practices and ensure the information is provided in ways that are culturally accessible and can be easily understood by that family.

To meet this Standard, all health workers must be able to:

1. Specifically discuss the six safe infant care practices and intended infant sleeping environment with families prior to discharge.
2. Discuss safe infant care practices and proposed sleeping arrangements with families on their return home and work in partnership with them to address any barriers to implementing safe infant care practices at home through the provision of culturally appropriate referrals, information and services based on the specific needs of the infant and the family.

Standard 4: All staff will ensure that expectant and new parents are made aware of the strong association between smoking and the increased risk of fatal infant sleeping incidents, and are supported and referred to smoking cessation or reduction programs.

There are no additional indicators of best practice specific to health workers for this Standard.

Standard 5: All staff will provide parents/caregivers and families with accurate information about a safe cot, with a safe mattress, safe bedding and in a safe environment.

To meet this Standard, all health workers must be able to:

1. Provide information and appropriate referrals to parents and caregivers at each point on the care continuum – from the first antenatal contact until the end of infancy.
2. Document information about discharge preparation and referrals to support safe infant sleeping on clinical care pathways and medical and nursing records for both parent and child.
3. Work in partnership with families to identify their reasons for being unable to provide a safe sleeping environment for their infant. These reasons could include cots given as family heirloom, financial constraints, high levels of transience, inadequate housing or other reasons.
4. Engage supports and referrals as appropriate.

Standard 6: All staff will ensure that expectant and new parents are made aware of the benefits of breastfeeding as a protective factor in reducing the risk of SIDS, and are later given support to breastfeed.

To meet this Standard, all health workers must be able to:

1. Provide information and appropriate referrals to parents and caregivers at each point on the care continuum – from the first antenatal contact until the end of infancy.
2. Document information about discharge preparation and referrals to support breastfeeding on clinical care pathways and medical and nursing records for the mother.
3. Work in partnership with expectant and new mothers to identify their reasons for being unable to initiate breastfeeding for their infant.
4. Engage supports and referrals as appropriate.
Appendix 2

Additional best practice indicators specific to Department for Child Protection staff and volunteers

All staff have a duty of care which extends beyond the individual child and includes other family members.

The role of the Department for Child Protection (DCP), as the statutory child protection agency is to provide assessment, education and support to parents and carers aimed at preventing sudden and unexpected infant death. Where the parenting environment has been assessed as being unsafe, DCP may take action to secure the care and protection of an infant under the Children and Young People (Safety) Act 2017. DCP workers, foster carers, relative/kinship carers and contracted out of home care service provider staff must adhere to the relevant policies, procedures and practices including:

- Aboriginal Child Placement Principle Policy,
- Care and Protection Assessment Framework Policy,
- Care and Protection Assessment Framework Practice Guidelines for Investigation and Assessment,
- Families SA safe sleeping procedure,
- Families SA Duty of Care for Children and Young People in Care Policy and Practice Guide,
- Relative Kinship and Specific Child Only Care Policy,
- Standards of Alternative Care in South Australia (specifically standard 3.7.1).

**Standard 1:** All staff will place well infants under 12 months on their back to sleep from birth, never on the front (tummy) or side, unless there are medically indicated reasons.

Best practice indicators

1. Foster carers, relative/kinship carers and contracted out of home care service provider staff who care for infants are informed about, and implement safe sleeping practices for infants under 12 months.

2. Foster carers, relative/kinship carers and contracted out of home care service providers staff who care for infants must seek advice from medical staff about positioning infants safely where a medical directive exists that requires the infant not to be placed on their back to sleep.
Best practice indicators

1. When investigating a notification, DCP staff must sight the infant, view the infants sleeping environment and discuss the sleeping arrangements with the infant’s parents/caregivers.

2. This is undertaken as part of the child protection assessment process, or it can be incorporated into an already existing assessment process (e.g. drug and alcohol assessment) which should explore how parents/caregivers who use drugs and/or alcohol will mitigate risks to their infants safe sleeping.

3. It is recommended that DCP staff demonstrate safe sleeping techniques to support parents/caregivers understanding of the importance of providing safe sleeping environments to their infants.

Standard 2: All staff will be fully informed about the risks of adults sharing the same sleep surface with an infant and promote the placing of infants for sleep in an Australian Standards compliant cot (AS/NZS 2172) in the same room as the parents for the first six to 12 months.

Best practice indicators

1. DCP recognises that families who are disadvantaged and marginalised may be harder to reach using traditional public health education strategies and therefore require more direct intervention to ensure that safe sleeping strategies are understood and implemented.

2. DCP staff must promote safe sleeping depending on the family’s circumstances (and unless it is not required due to good practices already being in place) including recommending that parents/caregivers do not share the same sleep surface with their infant due to risks associated with substance abuse, overlaying by another person and suffocation from pillows and blankets.

3. DCP staff will consult with the Principal Aboriginal Consultant to ensure engagement with Aboriginal and Torres Strait Islander families/carers/kin/community is supported in a culturally appropriate manner.

4. DCP staff will consult with other relevant cultural consultants to ensure engagement with families/carers/kin/community is supported in a culturally appropriate manner for those people from culturally and linguistically diverse backgrounds.

5. Staff must document in the investigation notes on C3MS what safe sleeping promotion was undertaken with the parents/caregivers, or why safe sleeping promotion was not required (i.e. the parents/caregivers were already practicing safe sleeping strategies).

Standard 3: All staff will consider the social, cultural and life circumstances of each family when promoting safe sleeping practices and ensure the information is provided in ways that are culturally accessible and can be easily understood by that family.
**Standard 4:** All staff will ensure that expectant and new parents are made aware of the strong association between smoking and the increased risk of fatal infant sleeping incidents, and are supported and referred to smoking cessation or reduction programs.

**Best practice indicators**

DCP staff will work in partnership with parents/caregivers to ensure that they are aware of the increased risk of SIDS associated with smoking and support them to engage with programs to address their smoking behaviour.

**Standard 5:** All staff will provide parents/caregivers and families with accurate information about a safe cot, with a safe mattress, safe bedding and in a safe environment.

**Best practice indicators**

1. There may be many reasons why parents/caregivers and families do not have safe cots or goods to provide a safe sleeping environment for their infants. Staff must work in partnership with families to identify the reasons for this such as financial constraints, high levels of transience, inadequate housing or other reasons.
2. Families who are disadvantaged may also find it harder to adapt their home environment to reduce the risk of SUDI, and therefore may require additional support to do so.
3. Where assessed to be appropriate, DCP workers should consider integrated practice with the DCP Financial Counsellor to assess the family’s financial difficulties/needs and assist the family to obtain safe cots, baby sleeping bags or appropriate bedding.
4. Staff must document what safe sleeping promotion was undertaken with the parent/caregiver.
5. Staff must document the parents/caregivers willingness and capacity to meet the needs of the infant as part of the overall assessment of risk to the infant.

**Standard 6:** All staff will ensure that expectant and new parents are made aware of the benefits of breastfeeding as a protective factor in reducing the risk of SIDS, and are later given support to breastfeed.

**Best practice indicators**

1. DCP staff will work in partnership with parents/caregivers to ensure that they are aware of the benefits of breastfeeding.
2. Engage supports and referrals as appropriate.
Appendix 3

Additional best practice indicators specific to Department for Education – Early Childhood Services staff and volunteers

It is important to acknowledge the critical role early childhood workers play in promoting and modelling safe sleeping practices and environments to families with infants.

The South Australian Safe Sleeping Standards have important implications for both Childcare Centres and Family Day Care workers in relation to the onus they place on staff and family day care providers to model and promote accurate information to parents about:

- placing infants under 12 months of age in an Australian Standards compliant cot, away from blind cords, with appropriate supervision and lighting,
- sleeping infants on their back, the effects of smoking and the risks of sharing the same sleep surface, and conveying this in a way that parents/caregivers of infants in their care can understand, and
- supporting mothers to maintain breastfeeding.
Appendix 4

Details of the original committee who developed the Standard

The initial Committee who developed the first standard included representatives from:

- The Centre for Health Promotion, CYWHS
- Health Promotion Branch, DoH
- SIDS and Kids SA
- Kidsafe SA
- Child and Family Health Services, CYWHS
- Families SA, Department of Families and Communities (DFC)
- SA Health Injury Surveillance and Control Unit
- Child Death and Serious Injury Review Committee
- SA DoH Maternal, Perinatal and Infant Mortality Committee
- Aboriginal Health Division, DoH
- Association of Neonatal Nurses
- Australian College of Midwives

In addition access to the following information supported the development of the Standard:

- the research carried out by Prof (Adj) Jeanine Young and Queensland Health identifying the important role health professionals play in the uptake of safe sleeping messages by parents,
- the Safe Infant Care to Reduce the Risk of Sudden Unexpected Deaths in Infancy Policy Statement and Guidelines developed by Queensland Health, and
- the expert advice received by the Head of Gastroenterology at the Women’s and Children’s Hospital South Australia, Dr David Moore and supported by a Cochrane Review, regarding the placement of infants, including those with gastroesophageal reflux.
Evidence

Challenges to meeting best practice, evidence and resources
10. **Evidence**: Challenges to meeting best practice, evidence and resources

**Standard 1**: All staff will place well infants under 12 months on their back to sleep from birth, never on the front (tummy) or side, unless there are medically indicated reasons.

<table>
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<th>Support and resources</th>
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| Parents and staff may hold personal views for not placing infants on their back. These may include: | All infants should be placed on their back to sleep. | [Sleep (Children 0–6 years) Parent Easy Guide](http://www.parenting.sa.gov.au/pegs/peg34.pdf)  
**Parent Helpline** can provide advice on settling – available 24 hours a day 7 days a week. **Ph. 1300 364 100**  
**Kidsafe SA and SIDS and Kids SA** can provide advice on safe sleeping and the risks and safety aspects of aids and devices for infant **Ph. 8161 6318 or Ph. 83321066**  
**SIDS and Kids** Information Statement ‘Wrapping Infants’ available at [www.sidsandkids.org](http://www.sidsandkids.org) Ph. 83321066  
| > Concerns about infants aspirating after feeding and regurgitating. | Studies have demonstrated that even in healthy infants, respiratory rates, swallowing and arousal are each reduced in the prone (tummy) position compared to the supine (back) position. There is no evidence to support the elevation of the head of the cot for Gastro-oesophageal Reflux Disease (GORD)\(^{37}\). |
| > Belief that the infant sleeps and settles better on their front (tummy) or side\(^ {38,39}\).  
> Difficulty settling and putting infant down to sleep. | Front (tummy) and side sleeping positions significantly increase the risk of SIDS, a finding supported by a large body of international studies\(^ {16,40-42}\). All aids and devices intended to keep infants in a certain sleep position are not recommended as they do not prevent infants from rolling on to their tummies and limit the movements of the baby as they get older. | |
### Standard 1: cont…

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<tbody>
<tr>
<td>Parents and staff may hold personal views for not placing infants on their back. These may include:  &gt; Concerns about misshapen head shape (plagiocephaly).</td>
<td>All infants should be placed on their back to sleep.</td>
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Positional plagiocephaly is a flattened spot on the head that can develop if an infant lies with their head in one position for long periods of time.

Studies have shown that there is no significant relationship between sleeping infants on their back and the development of deformational plagiocephaly; positional preference and infant care practices used by parents including the frequency of tummy time, played a greater role.

Some of the ways to prevent positional plagiocephaly are:

- Always place an infant to sleep on the back. Alternate an infant’s head position (left or right) when placed to sleep.
- From birth offer baby increasing amounts of time playing on the tummy while awake and watched by an adult.
- If bottle feeding, alternate the holding position when feeding the infant.

There is no evidence to suggest that sleeping an infant on their back affects brain development.

**SIDS and Kids Information Statement – ‘Baby’s Head Shape’** (under Information Statements) for information and strategies to reduce the risk of positional plagiocephaly, available at [www.sidsandkids.org](http://www.sidsandkids.org)

**Women and Children’s Health Network (WCHN)** for information sheet on plagiocephaly visit [www.cyh.com](http://www.cyh.com)

‘Tummy time’ brochure available from SIDS and Kids SA Ph. 83321066
## Standard 1:  cont.…

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<td>Parents and staff may hold personal views for not placing infants on their back. These may include:</td>
<td>All infants should be placed on their back to sleep.</td>
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<tr>
<td>&gt; Inconsistent role modelling by staff conflicts with these recommendations.</td>
<td>Many infants in neonatal special care units are placed on their front or side for medical reasons. However, premature and low birth weight infants are placed on their backs as soon as their oxygen requirements allow and well before discharge, to ensure that the infant and parents are accustomed to the infant being placed on its back to sleep.</td>
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<td>&gt; Observation on television or through other media which suggests front or side sleeping of infants is safe.</td>
<td>It is sometimes implied during advertisements or television programs that it is safe to place baby on the tummy or side to sleep. The side sleeping position is unstable and therefore increases the risk of SIDS by two to four times, attributed mainly to the side position being relatively unstable, resulting in some infants rolling to the tummy position during sleep and asphyxiating. Side sleeping is not recommended as a safe alternative to sleeping on the back. Positioning devices are also not recommended.</td>
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**Standard 2:** All staff will be fully informed about the risks of sharing the same sleep surface with an infant and promote the placing of infants for sleep in an Australian Standards compliant cot (AS/NZS 2172)\(^{44}\) in the same room as the parents for the first six to 12 months.

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| Familial reasons for sharing the same sleep surface with infants in preference to room-sharing. These may include:  

- Being too tired or exhausted to return baby to the cot after breastfeeding.  
- Having trouble settling their baby.  
- Falling asleep unintentionally on the couch.  
- Frequent changes to infant routines and usual sleeping environments lead to difficulty settling. | Infants are more at risk of SUDI and fatal sleeping accidents when adults share the same sleep surface with infants.  
It is not safe for anybody to fall asleep with an infant on the same sleep surface\(^{34}\). Placing an infant to sleep or falling asleep together with an infant on a bed, sofa or couch is extremely hazardous. There is a greatly elevated risk of infant death and sleeping accidents when an infant shares the same sleep surface (e.g. bed, sofa or couch) with an adult during sleep. The risks are increased when the parent or family member is under the influence of alcohol and/or other drugs or under the influence of medication that causes sleepiness and they share the same sleep surface.  
When infants become unsettled and have trouble sleeping, parents may be tempted to share the same sleep surface with their infant. Parents will benefit from setting advice ideas which can be found in the Sleep Parent Easy Guide.  
A bassinette or travel cot which has been specifically designed as an infant sleeping environment can be used for daytime sleeps and moved from room to room or used when visiting or moving from one house to another. | See *Coroner's Findings* in the matter of inquest number 6/2008. Adelaide: Courts Administration Authority SA; 2008 June p26\(^{45}\)  
Kidsafe SA can provide advice on the use of portable/travel cots Ph. 8161 6318  
[Parent Helpline](https://www.parenting.sa.gov.au/) can provide advice and support 24 hours a day 7 days a week Ph. 1300 364 100 |
**Standard 2:** cont.…

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<td>Families may cite reasons for sharing the same sleep surface with infants in preference to room-sharing. These may include:</td>
<td>Infants are more at risk of SUDI and fatal sleeping incidents when adults share the same sleep surface with infants.</td>
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<td></td>
<td>A portacot should only be used with the thin mattress which it comes with. No other mattress or padding should be added to the portacot. The mattress which the portacot comes with is designed to provide adequate comfort for the infant. Car seats, bouncinettes, hammocks, bean bags, pillows and sofas (armchairs, lounges, couches) are not designed as sleeping environments for infants and are not be used for that purpose.</td>
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| > Historically and culturally – adults sharing the same sleep surface with infants is considered normal.  
> Parents, particularly those for whom English is a second language, may not be aware of the risks of sharing the same sleep surface with infants. | Despite the practice of adults sharing a sleep surface with baby being common in culturally diverse communities, Coronial inquests have determined that sharing the same sleep surface with infants is a risk to all infants including those from culturally diverse backgrounds. Although it may seem difficult, it is essential that staff provide all families with information about the risks of sharing the same sleep surface with infants and the benefits of room-sharing regardless of the family’s cultural background. | **Aboriginal Maternal Infant Care (AMIC) Workers** provide Aboriginal Women with continuity of care for antenatal, birthing and postnatal services. They can be contacted through:  
> Women’s and Children’s Hospital  
Ph. 8161 7000  
> Lyell McEwin Hospital – Birthing and Assessment Unit  
Ph. 8182 9326  
> Northern Area Midwifery Group Practice  
Ph. 8252 3711, and  
> Nunkuwarrin Yunti  
Ph. 8406 1600 |

**Aboriginal Maternal Infant Care (AMIC) Workers** provide Aboriginal Women with continuity of care for antenatal, birthing and postnatal services. They can be contacted through:

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| > Lack of funds to purchase a cot | All families, particularly those from diverse backgrounds, need to be aware that the risks of sharing the same sleep surface with infants under 12 months are increased when protective factors such as a firm mattress or mat on the floor are substituted with softer sleeping surfaces. All parents also need to be particularly aware of the risks of sharing the same sleep surface with infants and smoking. Where possible: > Ask the parents or caregivers about the infant’s sleep environment at home. > If the caregiver consents and if home visiting takes place, take a look at the infant’s sleeping place. > Whether it is obvious that sharing the same sleep surface with an infant is occurring or not - discuss the risks of sharing the same sleep surface and the benefits of room sharing (including breastfeeding). | **Australian Refugee Association** provide assistance with community and cultural orientation and emergency financial and material assistance Ph. 8354 2951  
**Migrant Resource Centre** provides help with settlement, family relationships, counselling, financial support and emergency relief, CALD families and children’s support services. Ph. 8217 9510  
**Translating and Interpreting Service** provides professional translating services 24/7. Ph. 131 450  
Information about **Safe Sleeping resources** are available in other languages to download from the SIDS and Kids website [www.sidsandkids.org](http://www.sidsandkids.org) |

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| Families may cite reasons for sharing the same sleep surface with infants in preference to room-sharing. These may include:  
  > Parents being concerned about not being able to respond to baby quickly enough during the night. | Infants are more at risk of SUDI and fatal sleeping incidents when adults share the same sleep surface with infants.  
  > Note the discussion in the case notes and ensure relevant supports and services have been engaged.  
  Maternal awareness of the risk factors associated with SIDS and fatal sleeping incidents is likely to be lower where English is a second language or health literacy is low.  
  If parents use sharing the same sleep surface with infants as a means for settling their child before sleep, work in partnership with them to identify other settling strategies which enable them to return the infant to his/her own sleep surface or contact the Parent Helpline to get assistance with this.  
  Research in New Zealand and the UK has shown that sleeping an infant in the same room, but not in the same bed, with the parents for the first 12 months is protective. This is thought to be because parents can see the baby and easily check to see that baby is safe. Recent evidence from the UK indicates that sharing the same room during infant’s daytime sleeps is also protective. | See Coroner’s Findings in the matter of inquest number 6/2008. Adelaide: Courts Administration Authority SA; 2008 June p26.  
Cont… |
### Standard 2: cont.

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<td>Several studies have shown that when a caregiver sleeps in the same room, but does not share the same sleep surface with their infant, the chance of the baby dying suddenly and unexpectedly is reduced by up to 50% when compared to infants sleeping in a separate bedroom. If an infant is sleeping in a separate room, parents are not expected to observe their infant constantly but they should check the infant regularly to ensure that the infant remains on their back and the head and face remain uncovered (as an infant grows beyond 5–6 months they will move around the cot and may roll over). Room-sharing facilitates a rapid response to a baby’s needs, more convenient settling and comforting of infants, and closer mother-infant contact and communication. Room sharing is recommended for all infants although the room where an infant sleeps must be kept smoke free.</td>
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Standard 3: All staff will consider the social, cultural and life circumstances of each family when promoting safe sleeping practices and ensure the information is provided in ways that are culturally accessible and can be easily understood by that family.

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<td>Staff may miss opportunities for not providing information in culturally accessible and appropriate ways including:</td>
<td>Families need information to be provided in ways that assist them to make decisions and exercise greater control over their health</td>
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<tr>
<td>&gt; Assumptions of family literacy levels.</td>
<td>Much of the information provided to families assumes more than a basic level of health literacy. Prior to the birth and after the birth of an infant, families are exposed to an enormous amount of information from a variety of sources including media, marketing, ‘bounty bags’, nurses, doctors and family members. Unpublished market research conducted in Adelaide, South Australia in 2009, found parents and caregivers more likely to act on and understand information about safe sleeping when this information is provided verbally from a health professional. Parents stressed the importance of the relationship with nurses and health professionals as once at home with the infant they are often time poor, tired and stressed. Some parents also reported they relied very little on books, pamphlets and other written information preferring to act on experience. Cont….</td>
<td><strong>SIDS and Kids</strong> provide resources in a number of languages  <a href="http://www.sidsandkids.org">www.sidsandkids.org</a></td>
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**Standard 3: cont…**

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<td>It is essential that staff work in partnership with families and provide information in ways that assist families and caregivers to understand and implement safe infant care practices and that they encourage families to ask questions and critically consider the information available to them. The provision of this essential information to parents should be documented in client records for both mother and infant.</td>
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<td>&gt; Time taken to communicate effectively.</td>
<td>The time taken to communicate safe sleeping messages to families can significantly improve parents’ capacity to provide a safe sleeping environment for their infant and reduce unnecessary risks. Failure to communicate or the provision of inconsistent, wrong or misleading information, significantly impairs parental capacity to problem solve and make critical decisions around achieving recommended safe sleeping practices. Wherever possible information should be provided in the most appropriate language and format. Approximately 2.7 million Australians (18%) have difficulty understanding and using information relating to health issues.</td>
<td><strong>Aboriginal Maternal Infant Care (AMIC) Workers</strong> provide Aboriginal Women with continuity of care for antenatal, birthing and postnatal services. They can be contacted through:</td>
</tr>
<tr>
<td>&gt; Lack of knowledge about where to access culturally appropriate information and support.</td>
<td></td>
<td>&gt; Women’s and Children’s Hospital Ph. 8161 7000</td>
</tr>
<tr>
<td>&gt; Difficulties engaging with client relatives and kin.</td>
<td></td>
<td>&gt; Lyell McEwin Hospital – Birthing &amp; Assessment Unit Ph. 8182 9326</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt; Northern Area Midwifery Group Practice Ph. 8252 3711</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt; Nunkuwarrin Yunti Ph. 8406 1600</td>
</tr>
</tbody>
</table>

Cont…
Staff may miss opportunities for not providing information in culturally accessible and appropriate ways including:

<table>
<thead>
<tr>
<th>Challenges in meeting best-practice</th>
<th>Evidence supporting best practice</th>
<th>Support and resources</th>
</tr>
</thead>
</table>
| Merely translating written health information may exclude those who are illiterate or have exceptionally low literacy levels, regardless of the language used. Despite the difficulties that communication exchanges might present, it is very important that staff call on people who have credibility with the family or are able to effectively convey the messages and their importance. This may involve seeking people out who are able to help translate the information into the language or in a manner that is suitable and has meaning for the family. By doing this staff can ensure: | Families need information to be provided in ways that assist them to make decisions and exercise greater control over their health | **Australian Refugee Association** provides assistance with community and cultural orientation and emergency financial and material assistance  
Ph. 8354 2951  
**Migrant Resource Centre** provide help with settlement, family relationship counselling, financial support and emergency relief, CALD family and children’s support service  
Ph. 8217 9510  
**Translating and Interpreting Service** provide professional translating services 24/7  
Ph. 131 450 |
| > knowledge and understanding of safe sleeping messages by families is improved,  
> families have greater commitment and confidence to problem solve and overcome the barriers to implementing the safe infant care practices at home, and  
> they have a greater awareness of families’ needs and preferences. | | |

Many agencies now have Culturally and Linguistically Diverse (CALD) workers and Aboriginal Health or Liaison workers. Staff should familiarise themselves with these supports and call on them as needed.
**Standard 4:** All staff will ensure that expectant and new parents are made aware of the strong association between smoking and the increased risk of fatal infant sleeping incidents, and are supported and referred to smoking cessation or reduction programs.

<table>
<thead>
<tr>
<th>Challenges in meeting best-practice</th>
<th>Evidence supporting best practice</th>
<th>Support and resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant and new parents may not disclose their smoking status for a number of reasons</td>
<td>Infants of mothers who smoke or who are exposed to second hand smoke are more likely to be stillborn, born prematurely and of low birth weight and suffer perinatal death.</td>
<td></td>
</tr>
</tbody>
</table>
| Families and caregivers may underestimate the effects of smoking on infants and children. | Infants and children are at a higher risk of harm from passive smoking than adults because of their smaller, developing bodies, higher breathing rates and less developed respiratory and immune systems. Infants of mothers who smoke or who are exposed to second hand smoke are more likely to be stillborn, born prematurely and of low birth weight and suffer perinatal death. Specific effects of passive smoking on infants and children include SIDS; respiratory infections and conditions including croup, bronchitis, and pneumonia; ear infections; learning difficulties; behavioural problems; and increased likelihood of childhood asthma\(^{48-51}\). There is no safe level of passive smoke exposure, and even brief exposures can be harmful. The elimination of smoking in indoor spaces is the only way to fully protect children from exposure to second hand smoke. Primary sources of infants' and children's passive smoke exposure are the home and vehicle. | Smoking and Pregnancy booklet available from Quit SA – www.quitsa.org.au/aspx/order_online.aspx  
Quit SA can provide information and advice on how to quit smoking. Ph. 137848 or visit www.quitsa.org.au  
SIDS and Kids also have an information statement on Smoking – www.sidsandkids.org  
Cont... |

*INFORMAL COPY WHEN PRINTED*

South Australian Safe Infant Sleeping Standards

For Official Use-I3-A1
<table>
<thead>
<tr>
<th>Challenges in meeting best-practice</th>
<th>Evidence supporting best practice</th>
<th>Support and resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectant and new parents may not disclose their smoking status for a number of reasons:</td>
<td>Infants of mothers who smoke or who are exposed to second hand smoke are more likely to be stillborn, born prematurely and of low birth weight and suffer perinatal death.</td>
<td></td>
</tr>
<tr>
<td>A single cigarette smoked in a room with poor ventilation generates much higher concentrations of toxic substances in the air than normal, everyday activities in a city, while nicotine from second hand smoke is deposited on household surfaces and in dust. Environmental tobacco smoke permeates the entire house and lingers long after the cigarette has been extinguished, so smoking in certain rooms, at certain times, or by a window, fan or door is not safe.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>They are unaware of the opportunities pregnancy presents to quit smoking.</td>
<td>Pregnancy provides a unique window of opportunity to minimise smoking rates and increase the health of women and children. More women cease smoking in pregnancy than at any other time in life. One quarter of Australian women who are smokers when they become pregnant stop smoking. Most of the women who quit smoking spontaneously upon becoming pregnant have a non-smoking partner, are supported to quit, or have stronger beliefs about the dangers of smoking than do those who do not quit.</td>
<td>Quit SA can provide information and advice on how to quit smoking. Ph. 137848 or visit <a href="http://www.quitsa.org.au">www.quitsa.org.au</a></td>
</tr>
</tbody>
</table>
**Standard 5:** All staff will provide parents/caregivers and families with accurate information about a safe cot, with a safe mattress, safe bedding and in a safe environment.

<table>
<thead>
<tr>
<th>Challenges in meeting best-practice</th>
<th>Evidence supporting best practice</th>
<th>Support and resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents and staff may express reasons for not implementing safe sleeping environments including:</td>
<td>A safe sleeping environment is one where all potential dangers have been removed and the infant is sleeping in a safe place.</td>
<td></td>
</tr>
<tr>
<td>&gt; Belief that infant sleeps better with teddy bears and soft toys, a pillow or doona.</td>
<td>One of the key barriers to parents and caregivers implementing safe infant care practices is perceptions of infant comfort believing their infant sleeps better with a teddy or a pillow. It is critical that parents are provided with evidence-based health advice about not placing toys and pillows in the cot. Research has found that parents who have the opportunity to work in partnership with health professionals to problem solve the issues around comfort and protection for their infant are more likely to adopt safe infant care practices. Providing information in ways that allow parents to gain an understanding of the evidence which supports safe infant care practices, particularly those relating to the risks of asphyxiation (suffocation) and overheating due to soft toys, bumpers, pillows and doonas is essential.</td>
<td>SIDS and Kids SA can provide advice on creating and setting up a safe sleeping environment Ph. 83321066 <a href="http://www.sidsandkids.org">www.sidsandkids.org</a> SIDS and Kids also have an easy-to-read brochure with graphics of a safe cot and bedding on their website <a href="http://www.sidsandkids.org">www.sidsandkids.org</a> Kidsafe SA provide advice on the cot standards and safe sleeping environments Ph. 8161 6318 <a href="http://www.kidsafesa.com.au">www.kidsafesa.com.au</a></td>
</tr>
</tbody>
</table>

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South Australian Safe Infant Sleeping Standards

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Page 44 of 58
**Standard 5: cont…**

<table>
<thead>
<tr>
<th>Challenges in meeting best-practice</th>
<th>Evidence supporting best practice</th>
<th>Support and resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents and staff may express reasons for not implementing safe sleeping environments including:</td>
<td>A safe sleeping environment is one where all potential dangers have been removed and the infant is sleeping in a safe place.</td>
<td></td>
</tr>
<tr>
<td>&gt; Parental concerns about infant not being warm enough lead to over-dressing and overheating.</td>
<td>Infants regulate their temperature through the head, particularly the face. In a heavily wrapped infant, 85% total heat loss is through the face. If this normal method of heat loss is restricted by bedding covering the face, wearing a bonnet or tummy sleeping (partial face covering by mattress and/or bedding), there is the propensity for thermal stress to occur (overheating)(^37).</td>
<td><strong>SIDS and Kids</strong> provide an Information statement on Room Temperature <a href="http://www.sidsandkids.org">www.sidsandkids.org</a> and an information statement bedding amount recommended for safe sleep. The <a href="http://www.cyh.com">www.cyh.com</a> website provides a comprehensive explanation with pictures of the ins and outs of wrapping babies. The <a href="http://www.cyh.com">www.cyh.com</a> website provides a comprehensive explanation with pictures of the ins and outs of wrapping babies.</td>
</tr>
</tbody>
</table>
| > Lack of knowledge about Australian Standards for cots. | A safe cot is one that meets the Australian Standard for cots. All new and second-hand cots sold in Australia must meet the Australian Standard for Household Cots (AS/NZ 2172)\(^53\) and will carry a label verifying this. Portable cots sold in Australia must now also meet the Australian Standard AS/NZS 2195 for portable cots\(^39,54\). Unsafe cots and bedding; whether given as a well-meaning gift at a baby shower or passed down through the family as an heirloom, pose risks to infants. These are best kept for display only and not used where the infant sleeps. If you or a parent seeks information about the safety of a product, contact the Australian Competition and Consumer Commission. | **Kidsafe SA** website [www.kidsafesa.com.au](http://www.kidsafesa.com.au)

For Information on mandatory product safety [www.productsafety.gov.au](http://www.productsafety.gov.au)

| > Relatives and friends give bumpers and pillows as gifts or heirlooms. | | |
Services and information

Quick guide for help

Quick guide for information

References
11. Quick guide for help

This list is intended as a guide only and does not in any way intend to be an exhaustive list of all available services in South Australia.

<table>
<thead>
<tr>
<th>Challenges to Safe Practice</th>
<th>Services</th>
<th>Details</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sleep positioning</strong></td>
<td>Child and Family Health Nurses</td>
<td>Child and Family Health Nurses can provide support and advice to parents.</td>
<td>CaFHS appointment line Ph. 1300 733 606</td>
</tr>
<tr>
<td>Placing infant on back to</td>
<td>Kidsafe SA</td>
<td>Kidsafe SA provide advice on the risks and safety aspects of aids and devices for infants.</td>
<td>Kidsafe SA Ph. 8161 6318 <a href="http://www.kidsafesa.com.au">www.kidsafesa.com.au</a></td>
</tr>
<tr>
<td>sleep may raise:</td>
<td>SIDS and Kids SA</td>
<td>Provide bereavement counselling and safe sleeping advice.</td>
<td>SIDS and Kids SA Ph. 83321066 <a href="http://www.sidsandkids.org">www.sidsandkids.org</a></td>
</tr>
<tr>
<td>&gt; concerns about infants</td>
<td>SA Parent Helpline</td>
<td>Advice on settling infants is available from the Parent Helpline 24/7.</td>
<td>SA Parent Helpline Ph.1300 364 100 <a href="http://www.parenting.sa.gov.au/helpline.htm">www.parenting.sa.gov.au/helpline.htm</a></td>
</tr>
<tr>
<td>&gt; aspirating after feeding</td>
<td>Health Direct Helpline</td>
<td>24 hour call centre for non-urgent health advice.</td>
<td>Health Direct Helpline Ph. 1800 022 222</td>
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<td>and regurgitating.</td>
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<td>&gt; belief that infant</td>
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<td>&gt; sleeps and settles</td>
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<td>&gt; better on the front or</td>
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<td>side,</td>
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<td>&gt; difficulty settling and</td>
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<td>putting infants down to</td>
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<td>sleep,</td>
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<td>&gt; concerns about</td>
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<td>misshapen head (plagiocephaly).</td>
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<tr>
<td><strong>Cot bedding</strong></td>
<td>Child and Family Health Nurses</td>
<td>CaFHS nurses can demonstrate wrapping techniques and advise on appropriate infant bedding and settling techniques.</td>
<td>CaFHS appointment line Ph. 1300 733 606</td>
</tr>
<tr>
<td>Removing many forms of cot</td>
<td>SA Parent Helpline</td>
<td>Can provide advice on setting up a safe sleep environment for infants 24/7.</td>
<td>Parent Helpline Ph.1300 364 100 <a href="http://www.parenting.sa.gov.au/helpline.htm">www.parenting.sa.gov.au/helpline.htm</a></td>
</tr>
<tr>
<td>may raise:</td>
<td>Kidsafe SA</td>
<td></td>
<td>Kidsafe SA Ph. 8161 6318</td>
</tr>
<tr>
<td>&gt; concerns baby will get</td>
<td>SIDS and Kids SA</td>
<td>Provide bereavement counselling and advice about creating a safe sleeping environment for infants.</td>
<td>SIDS and Kids SA Ph. 83321066 <a href="http://www.sidsandkids.org">www.sidsandkids.org</a></td>
</tr>
<tr>
<td>cold without a doona, hat,</td>
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<td>duvet etc.</td>
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<tr>
<td>&gt; belief that baby sleeps</td>
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<tr>
<td>better with toys, pillow</td>
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<tr>
<td>or sheep skin in the cot,</td>
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<td>&gt; no funds to purchase</td>
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<tr>
<td>baby sleeping bag.</td>
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<tr>
<td>Smoking at home</td>
<td>Room sharing</td>
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</tr>
<tr>
<td><strong>Families &amp; caregivers:</strong></td>
<td><strong>Sleeping an infant in their own cot located next to the parent’s bed or in the same room as the parents could present difficulties if there is:</strong></td>
<td></td>
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</tr>
<tr>
<td>- underestimate the effects of smoking on infants,</td>
<td>- no access to a cot,</td>
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<tr>
<td>- are unaware of the association between smoking and fatal sleeping incidents,</td>
<td>- no funds for a cot,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- are unaware of the opportunities pregnancy presents to quit smoking.</td>
<td>- no room for a cot in the parent’s bedroom,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quit SA</td>
<td>Aboriginal Maternal Infant Care Workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides state-wide programs to help smokers quit smoking.</td>
<td>Aboriginal Maternal Infant Care Workers provide Aboriginal Women and their families with continuity of care for antenatal, birthing and postnatal services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quit SA Ph.137 848</td>
<td>AMIC workers can be contacted through:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Women’s and Children’s Hospital Ph. 8161 7000 |
- Lyell McEwin Hospital – Birthing & Assessment Unit Ph. 8182 9326 |
- Northern Area Midwifery Group Practice Ph. 8252 3711 |
- Nunkuwarrin Yunti Ph. 8406 1600 |

Department for Education and Child Development (DECD) – Families SA Can provide information and access to financial services, housing services and family support for those in the child protection system. The DECD website has location and contact details of services provided www.decd.sa.gov.au
<table>
<thead>
<tr>
<th>Agency</th>
<th>Services</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| Centacare Lutheran Community Care          | These 4 agencies can provide emergency financial assistance and housing support in certain circumstances, and some provide services in country areas. | Their websites have location and contact details of services available:  
Centacare [www.centacare.org.au](http://www.centacare.org.au)  
Lutheran Care [www.lccare.org.au](http://www.lccare.org.au)  
Uniting Care Wesley [www.ucwpa.org.au](http://www.ucwpa.org.au) |
<p>| Nunkuwarrin Yunti of SA                    | Provide access to paediatrician services for Aboriginal families.         | Nunkuwarrin Yunti Ph. 8406 1600                           |
| Translating and Interpreting Service (TIS) | Provide professional translating services 24/7.                          | Translating and Interpreting Service (TIS) – Ph. 131 450 and quote your service’s client no. |
| Migrant Health Service                     | The MHS provides culturally appropriate medical care for migrants, refugees and asylum seekers. Training, advice and information is also provided to individuals and groups. | Migrant Health Service Ph. 8237 3900                      |
| Migrant Resource Centre (MRC)              | Can provide help with settlement, financial support and emergency relief, CALD family and children’s support service. | Migrant Resource Centre (MRC) Ph. 8217 9510               |</p>
<table>
<thead>
<tr>
<th><strong>Difficult social, cultural and life circumstances</strong></th>
<th><strong>Nunkuwarrin Yunti of SA</strong></th>
<th><strong>Have access to psychologist and psychiatric services for Aboriginal families.</strong></th>
<th><strong>Nunkuwarrin Yunti Ph. 8406 1600</strong></th>
</tr>
</thead>
</table>
| Difficulty implementing safe infant care practices due to: | **Alcohol and Drug Information Service helpline** | Provide confidential alcohol and drug counselling 24/7. If an interpreter is needed, ring the Translating and Interpreting Service on 13 1450 and ask to be connected to the SA Alcohol and Drug Information Service. | **Alcohol and Drug Information Service helpline**  
Ph. 1300 13 1340  
South Australian callers – local call fee  
Or phone Translating and Interpreting Service on 131450 for an interpreter |
> poor emotional health and wellbeing, anxiety, depression,  
> recent migration,  
> cultural and linguistic diversity,  
> limited mental capacity,  
> drug/alcohol use,  
> violence,  
> young parents. | **Beyond Blue Info Line** | Provides access to information and referral to relevant services for depression and anxiety. | **Beyond Blue Info Line Ph. 1300 22 4636** |
|  | **Families SA** | Can provide access to financial services, housing services and family support for those in the child protection system. Families SA has a specific role to protect children. Any concerns about the safety and wellbeing of infants and children can be made to the *Child Abuse Report Line* which operates 24/7. | **The Department for Education and Child Development DECD website has location and contact details of services provided**  
The Child Abuse Report Line  
Ph. 131 478 is a part of Families SA. |
|  | **Louise Place (Centacare)** | Louise Place is a 24hour supported accommodation service for young women who are pregnant or parenting and who are homeless or at risk of homelessness, during their pregnancy and in the early months of parenting. They also provide an outreach service. | **Louise Place can be contacted directly on Ph. 8272 6811** |
| **Migrant Health Service (MHS)** | The MHS provides culturally appropriate medical care for migrants, refugees and asylum seekers. Training, advice and information is also provided to individuals and groups. | Migrant Health Service Ph. 8237 3900 |
| **Migrant Resource Centre (MRC)** | The MRC provides help with settlement, family relationship counselling, financial support and emergency relief, CALD family and children’s support service. | Migrant Resource Centre Ph. 8217 9510 |

| **Difficult social, cultural and life circumstances** | Difficulty implementing safe infant care practices due to: |  |
| | - poor emotional health and wellbeing, anxiety, depression, |  |
| | - recent migration, |  |
| | - cultural and linguistic diversity, |  |
| | - limited mental capacity, |  |
| | - drug/alcohol use, |  |
| | - violence, |  |
| | - young parents. |  |

| **Translating & Interpreting Service (TIS)** | Provide professional translating services 24/7. | Translating and Interpreting Service Ph. 131 450 and quote your service’s client number |

| **Men’s Line** | Provides a dedicated service for men with relationship and family concerns 24/7. | Men’s Line Ph. 1300 789978 [www.mensline.org.au](http://www.mensline.org.au) |

| **Domestic Violence Crisis Service** | These are just a starting place to contact Aboriginal workers located in the Northern and Southern regions of SA providing advice and assistance responding to domestic violence. |  |
| **1300 782 200** Mon–Fri (9am–4pm) Police 131 444 Central Eastern Domestic Violence Service - CALD workers may be available 08/ 8365 5033 |  |  |

| **Northern:** |  |  |
| Muna Paiendi Ph. 8182 9206 |  |  |

| **Southern:** |  |  |
| ATSI Primary Health Care Team Ph. 8384 9266 |  |  |
| Aboriginal Family Clinic Ph. 8179 5943 |  |  |
| Flinders Medical Centre - Karpa Ngarrattendi Ph. 8204 5012 |  |  |
12. Quick guide for information

The Child and Family Health Service website [www.cyh.com](http://www.cyh.com) provides a comprehensive range of up-to-date evidence-based information about safe sleeping for infants. Another useful source of information is the SIDS and Kids website [www.sidsandkids.org](http://www.sidsandkids.org).

Listed below are further information sources available to families seeking evidence-based information about safe infant sleeping environments and care practices.

<table>
<thead>
<tr>
<th>Safe infant care</th>
<th>Information service</th>
<th>Details</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head shape (plagiocephaly)</td>
<td>Child and Family Health</td>
<td>‘Plagiocephaly’ ‘Baby’s Head Shape’</td>
<td><a href="http://www.cyh.com">www.cyh.com</a> <a href="http://www.sidsandkids.org">www.sidsandkids.org</a></td>
</tr>
<tr>
<td>Wrapping Infants</td>
<td>SIDS and Kids SA</td>
<td>‘Wrapping Infants’ Info Sheet</td>
<td><a href="http://www.sidsandkids.org">www.sidsandkids.org</a></td>
</tr>
<tr>
<td>Tummy time</td>
<td>SIDS and Kids SA</td>
<td>‘Tummy time’ brochures</td>
<td>SIDS and Kids Ph. 83321066 <a href="http://www.sidsandkids.org">www.sidsandkids.org</a></td>
</tr>
<tr>
<td>Post-natal depression/anxiety</td>
<td>Beyond Blue</td>
<td>Provide information about mental health, anxiety and depression on their website</td>
<td>Ph. 1300 22 4636 <a href="http://www.beyondblue.org.au">www.beyondblue.org.au</a> <a href="http://www.cyh.com">www.cyh.com</a></td>
</tr>
<tr>
<td>Culturally and linguistically diverse written information</td>
<td>SIDS and Kids</td>
<td>SIDS and Kids provide information sheets in other languages</td>
<td><a href="http://www.sidsandkids.org">www.sidsandkids.org</a></td>
</tr>
</tbody>
</table>
13. References


14. Ibid.


18. Monash University, loc. cit.

19. Ibid.


22. Monash University, loc. cit.


26. Ibid.

27. Ibid.


30. Ibid.

8. Document Ownership & History

Document developed by: Child Health Strategy, Women’s and Children’s Health Network
File / Objective No.: eA891217 – DHA2015-06350/1
Next review due: 16/10/23
Policy history:
Is this a new policy (V2.1)? N
Does this policy amend or update an existing policy version? Y
If so, which version? V2.0
Does this policy replace another policy with a different title? N
If so, which policy (title)?

ISBN No.: 978-1-76083-079-3

<table>
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<th>Version</th>
<th>Who approved New / Revised Version</th>
<th>Reason for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/10/18</td>
<td>V2.1</td>
<td>Interim Director Health Informatics, Performance, Planning &amp; Outcomes WCHN</td>
<td>Minor changes in line with Legislation</td>
</tr>
</tbody>
</table>
References


32. Ibid.

32. Monash University, loc. cit.


32. Monash University, loc. cit.

32. Ibid.


32. Monash University, loc. cit.


32. Ibid.

32. Ibid.

32. Monash University, loc. cit.

32. Joint Technical Committee CS-003. Australia/New Zealand Standard 2172: Cots for household use – Safety requirements. Sydney/Wellington: Standards Australia/Standards New Zealand; 2013 Apr

32. Ibid.


34. Joint Technical Committee, loc. cit.


44. Joint Technical Committee, loc. cit.


54. Ibid.

55. Ibid.