North Yorkshire
Safeguarding Children Partnership

7 point briefing

Child V - The importance of tailoring safe sleep messages to individual family circumstances, particularly where there are additional risk factors

February 2024

1 Context

Child V was a four-month-old baby who sadly died while sharing a bed with their parents. At the time of their death Child V was subject to a child protection plan for concerns regarding historical substance use, domestic abuse and risks posed in relation to parent's wider family. Having recently come out of the Public Law Outline process it should be noted that both parents were working well with agencies and were clearly demonstrating prioritising the needs of Child V despite their challenges.

2 Background

- Child V's parents had both experienced significant challenges throughout their own childhoods.
- Child V's father had spent time in the care of the Local Authority, had been in prison and described himself as having mental health issues and neurodiversity. Child V's father had an older child who was subject to a full care order.
- Child V's mother had experienced parental domestic abuse and physical harm resulting in her being subject to a child protection plan. Child V's mother also had difficulties with substance use, anti-social behaviours and had also been the victim of exploitation.
- At the time of Child V's conception both parents were living in temporary accommodation with other adults, one of whom was assessed as being an unsafe person for Child V to be in contact with.

3 Tasks/Challenges/Recommendations

Safe Sleep Messages
Child V and his family had a number of areas of risk, such as parental Adverse Childhood Experiences (ACES), smoking in pregnancy and low birth weight and while it is clear that safe sleep messages were provided by various professionals working with the family, it was not clear how well parents understood the risks in relation to co-sleeping for their particular circumstances.

- Consideration therefore needs to be given to how safe sleep conversations can be tailored to the specific family receiving the messages with additional consideration and discussion taking place where there are multiple risk factors that would make bed sharing between a child and parent unsafe. Parents' records need to reflect the narrative of these tailored discussions.

The National Panel's 2020 report, **Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (publishing.service.gov.uk)** suggests professionals, "consider how targeted interventions that provide a safe infant sleep space with comprehensive face-to-face safe sleep education can be embedded in wider whole family initiatives to promote infant safety, health and wellbeing." Child V's mother was accompanied at appointments by members of her wider family at key contacts however it does not appear these adults were included in the discussions regarding safe sleep for Child V.

- Safe sleep should be part of all child protection plans for children under one year of age and there will be a focus on how to revisit relevant conversations if new information arises or circumstances change. All agencies having significant involvement with the family should be included in the sharing of these conversations.

Ensuring a shared understanding of the level of risk
Reviewing Child V's records for this review, whilst it was clear when the Signs of Safety Score was increased, it was less clear what the evidence was that led to that decision. In addition, it was not clear how this level of risk influenced the level of support that was offered by the health visiting service

- When changes to the Signs of Safety scoring are made, there needs to be a clear explanation and narrative of how the cumulative risk has increased or decreased.
- Consideration should be given to when the health visiting enhanced pathway should be offered, particularly where numerous known vulnerabilities exist. In such cases best practice would be for a minimum of monthly visits to take place and these visits should be completed by the same worker to ensure consistency and to reduce difficulties in information sharing

Understanding men's lives and their experiences
In previous reviews the issue regarding the inclusion of fathers' details has been highlighted. The National Panel's report, The Myth of Invisible Men (publishing.service.gov.uk) states, "Fathers' are not a homogenous group and should not be approached as such. Those who are non-resident, those who are from an ethnic minority or those from white working-class backgrounds are all likely to face particular and different circumstances and pressures. These need to be understood and assessed as they apply for that individual and not be based on assumption or stereotypes."

Child V's father being registered at a different GP Surgery to that of Child V and the mother resulted in father's medical records not being requested or shared at the Initial Child Protection Conference (ICPC) or subsequent meetings. Despite Child V's father being in attendance at the majority of the antenatal and postnatal appointments he was not asked about his own mental health at these key points of contact with professionals.

- The review on Child V's review recommends that there needs to be greater consideration for how fathers' historical and current information is gathered, analysed and used to form multi-agency plans.
- It is noted that the Perinatal Maternity notes do not include questions related to partners' substance or alcohol misuse. The National Perinatal Record Templates need updating so they encourage practitioners to explore, address and record fathers' needs. This recommendation has been highlighted to the National Panel through Child V's review process.
- Trusts within North Yorkshire should consider how they can amend their IT systems to incorporate fathers' information. Harrogate District Foundation Trust (HDFT) are establishing a task and finish group to consider this.

Housing

When Child V was born, parents were living in temporary accommodation. A Home Environment Assessment Tool (HEAT) assessment can be carried out by any professional with the health visiting service being mandated to complete. It is recognised that SUDI risks increase when families are living in temporary accommodation so the fact that a family is in temporary accommodation should not lead to the Home Environment Assessment Tool (HEAT) assessment being deferred.

- Home Environment Assessment Tool (HEAT) assessments should be carried out in temporary accommodation and in any subsequent accommodation the family move to.
- Conversations within both midwifery and health visiting services are required to consider when Home Environment Assessment Tool (HEAT) assessments should be completed and who should complete them. Reducing the number of involved professionals may also support with this, along with ensuring robust handover discussions take place between all involved practitioners.

4 Good Practice

- The vulnerability factors for both parents were recognised at the antenatal booking appointment and a safeguarding referral was immediately made to the Multi-Agency Screening Team.
- The Strategy Meeting and Initial Child Protection Conference (ICPC) recognised the concerns, and a multiagency plan was developed. In view of the seriousness of the concerns the Public Law Outline (PLO) process was initiated. There was good multiagency involvement and attendance at all meetings.
- Most agencies involved with the family addressed safe sleep which mother was able to reflect on in her police statement.
- The housing officer knew who to contact when he had concerns about substance misuse. His concerns were listened to, and home visits carried out to assess these concerns
- Professionals regularly checked with mother regarding her mental health and asked questions regularly about Domestic Abuse
- Probation were aware of father's substance misuse through discussions at the Initial Child Protection Conference (ICPC) and Review Child Protection Conferences (RCPC) and as such, work was completed with father at key points of contact.
- Child V and his parents were at the centre of multi-agency plans with clear evidence of relational based practice being in evidence throughout the work completed with the family.

5 Update

Practitioners directly involved with Child V will receive feedback as part of the Rapid Review process.

The "Frontline Five" will be shared with all practitioners across the partnership to highlight the five key ways practitioners can implement the learning from this review.

6 Actions

A point of learning will be to ensure the NYSCP #AskMe Campaign which includes the Day, or Night Sleep Right message reaches all partner agencies and that it reiterates all professionals' responsibilities to share key messages with parents and carers at key points of contact. For these families with multiple vulnerabilities there should be multiple workers delivering these messages. An anonymised action plan based on the recommendations will be reviewed through the Practice and Learning Subgroup.

7 Resources professionals may find useful:

The Myth of Invisible Men (publishing.service.gov.uk)

Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (publishing.service.gov.uk)

#AskMe Campaign

Day or Night Sleep Right

Signs of Safety