North Yorkshire
Safeguarding Children Partnership

Safeguarding Practice Review - Child I

Baby who died whilst co-sleeping. October 2025

The purpose of the child safeguarding practice review process, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children. They should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account. Sharing from the learning of these reviews is vital for all practitioners to reflect on to ensure practice is continually evolving in the best interest of children, young people and families.

Introduction

Child I was a 12-week-old baby who sadly died after being found unresponsive while co-sleeping with a parent and sibling. Child I was subject to a Child in Need (CIN) plan at the time. and had multi-agency involvement, including Children's Social Care, Health Visiting, and Police. The cause of Child I's death was unascertained, but circumstances included parental alcohol use and a very warm sleeping environment. The review focused on multi-agency learning to strengthen safeguarding practice across North Yorkshire.

Please note this is being published following the conclusion of ongoing processes. Actions have been reviewed as part of the NYSCP Practice & Learning Subgroup

Areas of Good Practice

- **Safer Sleep Advice:** Health professionals (midwifery and health visiting) provided repeated, clear advice on safer sleeping arrangements, including risks associated with alcohol and drug use.
- **Information Sharing**: The Home Environment Assessment Tool (HEAT) was used effectively by health visitors. The HEAT tool is designed to help practitioners identify those families where there may be early signs of neglect.
- **Domestic Abuse Notification:** Police procedures for notifying midwifery services about domestic abuse incidents were highlighted as effective
- The child's mother stated she had been treated with respect and kindness by all agencies involved throughout the review process.

Areas for Development

- **Timeliness of Assessment:** Delays in gathering information from partner agencies and convening multi-agency meetings during the CIN assessment period.
- **Multiagency Meetings:** Earlier multi-agency meetings could have facilitated better information sharing and planning, especially where assessments exceeded 20 working days.
- **Information Sharing:** Siloed working was identified, with some agencies unaware of ongoing assessments, reducing opportunities for information sharing and professional challenge.
- **Health Liaison:** Notification of pregnancy from midwifery to health visiting was delayed, and linkage of sibling records was inconsistent.
- **Professional Curiosity:** Opportunities to explore and address parental alcohol use and conflict were sometimes missed.

Context

At the time of Child I's death, the family was undergoing an assessment by Children's Social Care under Section 17 (Child in Need) , which included an evaluation of Child I's needs. The family was also receiving support from the Health Visiting Service.

However, there were additional concerns, including reports of domestic abuse and parental conflict, a history of police involvement and a maternal history of substance and alcohol misuse.

It should also be noted that this incident happened during the Covid 19-Pandemic.

Resources & Further Information

All NYSCP practice guidance can be accessed here.

- Day or Night: Sleep Right
- #AskMe... have the Conversation
- Managing Different Professional Perspectives and Mutual Challenges (Including Professional Resolutions)
- Professional Curiosity
- HEAT Tool
- Strength in Relationships Practice Model
- Information Sharing

Learning from other Safeguarding Practice Reviews can be accessed here.

Get in touch

To make a safeguarding referral about an adult or child call: 0300 121 3 121

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Recommendations (actions are now completed with updates in bold)

- Formal Debrief: All practitioners involved in reviews should receive a formal debrief for shared learning. **A full debrief was completed with all staff, including a review of recommendations and reflection for practice.**
- Safer Sleep & SUDI Prevention: Endorse and promote the "Prevent and Protect" model for safer sleep and Sudden Unexpected Death in Infancy (SUDI) prevention, with multiagency training and resources. Multi-agency training and guidance delivered under "Day or Night Sleep Right"; resources and #AskMe Campaign. **Agencies endorsed and integrated the guidance into their procedures. Key leads delivered presentations and training across agencies, and the relevant learning resources were made available to frontline practitioners.**
- Assessment Standards: All Children and Family assessments should follow standards for identifying and contacting relevant agencies, with clear notification to GPs. **Assurance given that all teams were reminded of the standard required regarding CIN meeting attendance. Further assurance was sought that teams were reminded of the need to ensure that GPs were notified of assessments and outcomes.**
- Multi-agency Meetings: Where assessments exceed 20 working days, a multi-agency meeting should be held or a clear rationale recorded. **Assurance provided by partners that if an assessment exceeds 20 working days, a multi-agency meeting will be held or a clear rationale will be recorded. This has been undertaken through briefings and group supervisions.**
- Health Liaison: Improve liaison and timely notification between midwifery and health visiting, especially for vulnerable families, and ensure relevant health information is linked across sibling records. **Hospital Trusts reviewed their current liaison systems between Midwifery and Health Visiting Services and strengthened the process. There was a particular focus on the timely notification of pregnancy from Midwifery to Health Visiting and further developing systems for liaison with vulnerable families.**

Questions for Reflection

- How are we, as a partnership, ensuring effective multiagency information sharing to safeguard children?
- How do we ensure that families are given open and safe opportunities to have conversations about the challenges and that messages in relation to safe sleeping, feeding, etc, are completed so they encourage conversation, rather than just relaying information.
- In what ways do our collective approaches to risk identification and management address vulnerabilities such as parental substance misuse, domestic abuse, and environmental factors?
- How do we promote and sustain professional curiosity and challenge across all agencies?
- What systems are in place to ensure timely assessments and coordinated multiagency responses for children and families?
- How do we ensure that learning from safeguarding reviews is embedded and sustained in everyday practice?

What to do now

- Consider the questions for reflection in your team meetings and think about how the learning can be embedded into practice.
- Familiarise yourself with the additional resources and information. and promote across your teams.
- Share your learning and the key messages with your colleagues.

Further partnership Audits and Safeguarding Reviews can be accessed here.

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