Review concerning a 3-month-old baby
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7 POINT BRIEFING

1 SUMMARY

Wakefield Safeguarding Children Partnership (WSCP) undertook a review concerning a 3-month-old baby following their sudden and tragic death at home due to overlay. There are no indications or suggestions abuse and/or neglect caused the death, but additional risk factors were present within the family household.

The areas the review identified included the following:

1. Presentation of domestic abuse and responses to intervene
2. Impact of parental alcohol and drug misuse and mental-ill health
3. Effectiveness of safe sleep provision
4. Working with men
5. Understanding family history and professional challenge of each other to inform assessment, planning and intervention
6. Working with parental resistance and dishonesty through professional curiosity
7. Impact of Covid-19

2 WHO WAS THE BABY AND THEIR FAMILY?

The baby was 3 months old at the time of their death and lived with their mum and three older siblings. At the time of baby's death, it was understood that parents were separated after a domestic abuse incident, where dad was not to reside at the house as part of the safety plan. Since baby's death it has been confirmed dad was continuing to reside at the family home frequently.

The family had a history of contact and support from several organisations with periods of statutory intervention. The trio of vulnerabilities (previously known as toxic-trios) domestic abuse, alcohol and drug misuse and episodes of parental mental ill-health were long standing and prevalent features when reviewing the family's chronology.

3 SUMMARY OF THE INCIDENT

Mum reported that she had given baby a feed at around midnight the previous evening and both had gone to sleep on the sofa. When mother had woken the following morning, baby was found to be non-responsive. Baby was sadly pronounced deceased at the hospital. There were some emerging concerns about the potential for one or both parents to have used drugs on the evening of baby's death and considerations as to whether this could have been a factor in the sleeping arrangements. Further investigations were undertaken and subsequently mum disclosed she had taken cocaine and said dad had also done so. In exploring these issues, it further came to light that the children may have been left at home for a period during the evening of baby's death.

4 KEY POINTS AND ANALYSIS FROM THE REVIEW

1. Presentation of domestic abuse and response to intervene

- Domestic abuse was a consistent feature within the family household and recognised by services who worked with the family from when the eldest child was born. The parent's relationship spanned 12 years with periods of separation and reconciliation. Both parents were recognised by services as both being victims and perpetrators of domestic abuse
- There was an overreliance on parents separating and centring intervention on the removal of the father from the household. Where periods of relative stability were present, there was missed opportunity to undertake intervention to address underlying behaviours with both victim and perpetrator to prevent or reduce the risk of recurring domestic abuse
- Information on previous domestic abuse incidents was not shared with all appropriate services. School paper based system for recording resulted in information not being transferred to records and shared with wider designated safeguarding lead team
- Services within the review acknowledged there was a need to consider within assessment and safety planning how parents would continue to interact with one another based on their history, whether they were acknowledging being in a relationship or not bared little relevance when placed within this context
- There was an absence of understanding and acknowledgement as to the impact domestic abuse can have on victims, particularly those who are being subjected to coercive control

2. Impact of parental alcohol and drug misuse and mental ill-health

- Parents had long history of alcohol and drug use, but drug and alcohol services involvement was only recent. There was a lack of awareness that partner services can refer adults to drug and alcohol services alongside self-referral
- There was an absence within service assessment as to how parent's mental-ill health impacted on the children and how this informed planning and intervention to mitigate risk

3. Effectiveness of safe sleep provision

- Prior to this incident, services did ask to view where a baby is sleeping. This has now become part of routine practice amongst Health Visiting and Community Midwifery teams
- What is understood from other sudden infant deaths arising from unsafe sleep occurrences there is likely to be additional safeguarding risks such as parental alcohol and drug use, smoking, domestic abuse, and parental mental-ill health. There is a need for a more targeted approach to safe sleep provision which is not just reliant on health services to deliver this to this cohort of higher risk families

4. Working with men

- There is a need to ensure there is a flexible approach which is tenacious in seeking engagement with absent parents. This was particularly pertinent with father, given the risk he posed based on the history of domestic abuse and alcohol and drug use. When it appeared, parents had separated it was unclear as to how services still maintained visibility of father to ensure plans anticipated how he may still maintain contact

5. Understanding family history and professional challenge of each other to inform assessment, planning and intervention

- Reviewing the history provided a clear indication that there was a likelihood parents may reconcile and there was generally an absence within planning as to how this would be managed
- When services believed father was not residing at the family home, enquiring about the status of parent's relationship through routine enquiry was not within records. There is a partnership wide development ongoing in Wakefield at present in relation to relationship enquiry to increase levels of understanding, knowledge, and confidence for the workforce to have this approach embedded within practice
- Throughout the family's history there was limited evidence as to how offers of non-statutory support at the point of stepping down from statutory intervention was considered by services. Furthermore, how those offers of non-statutory support could be framed to parents to ensure there was a clear plan to consider stepping back up to statutory intervention could be triggered should there be disengagement
- Baby's eldest sibling was referred for mental health support by school, at aged 5 years in relation to heightened anxiety and aggression. Services recognised that a child at such a young age being referred for mental health support should have raised further lines of enquiry as to what the lived experience of the children was at home

6. Working with parental resistance and dishonesty through professional curiosity

- Being professionally curious and challenging in the face of parental resistance and dishonesty can be a complex and difficult approach to maintain. It can lead to confrontation from parents and complaints. It was recognised that there is a need for an authorising culture at a senior level in services which not only promotes professional curiosity and challenge, but demands this approach and provides a safe and nurturing environment for practitioners to feel confident to undertake this without a sense of potentially being undermined or reprimanded should there be occasions where curiosity and challenging is misdirected when the intentions have a strong rationale
- It was recognised the manipulation and disguised compliance from parents seemed to bring about an approach in being over optimistic on testimonies and commitments without triangulating this with a robust and co-ordinated multi-agency approach which had clear plans on escalation and tested parental accounts

7. Impact of Covid-19

- The quality of multi-agency working in this case was limited. Upon reflection there was a sense of the lost connectivity with services not being co-located to share information and form relationships contributed to this
- There were occasions within the period of service involvement prior to baby's death where home visits were attempted by practitioners without success in gaining entry. Face-to-face service provision was inconsistent amongst partner agency and third sector commissioned organisations during the Covid-19 pandemic period. This would have enabled already resistant parents to disengage more readily. During the pandemic, group work such as programmes to address domestic abuse was impacted due to the requirement of social distancing
- School absence for the elder children was in line with the reduced rates of attendance seen nationally since the pandemic. School acknowledged that absence due to Covid-19 was referenced for the children and on reflection may have supported children being hidden from professional's sight

5 WHAT WILL WE DO WITH THESE FINDINGS?

- The review generated individual, group and system recommendations which are being overseen and implemented by WSCP multi-agency subgroups which are represented by services who work or volunteer with children and families
- WSCP will hold practice review briefings to disseminate the learning and analysis to the children and families workforce

6 NEXT STEPS

- The findings of the review have been approved by WSCP and work is underway in implementing the learning from the incident
- WSCP will consider holding service challenge events for those services involved in the review to report back on how they have implemented recommendations

7 RESOURCES

There are a range of national and local resources and guidance in relation to Safeguarding Babies and Infants, including Safe Sleep on the WSCP website – Safeguarding Babies and Infants page:

- **Wakefield Safe Sleep Standard**
- **Wakefield Safe Sleep Multi-Agency Training**
- **Recent Safeguarding Babies & Infants Masterclass Part 1**
- **Recent Safeguarding Babies & Infants Masterclass Part 2**

Wakefield Safeguarding Children Partnership