Wakefield Safeguarding Children Partnership

Local Child Safeguarding Practice Review concerning 'David'

Executive Summary

Published September 2021

1. Introduction

The Local Child Safeguarding Practice Reviews (LSCPR) concerning 'David' was commissioned by Wakefield Safeguarding Children Partnership (WSCP) in June 2020 respectively following David's sudden and tragic death at home. The review was commissioned in line with statutory guidance (HM Government, 2018) and covered the period for June 2017 to January 2020.

WSCP in agreement with the independent author have produced an Executive Summary to provide an overview of the learning identified.

The themes the independent author considered included:

1. Awareness of reducing SUDI[1] and overlaying risk
2. Multi-Agency working together
3. Presentations of neglect
4. Seeing the world of the child through their eyes
5. Service assessment and planning

Reports from ten agencies involved with David and their families were submitted respectively for the purposes of the review.

Three multi-agency panel meetings were held for the review, along with learning events involving front line practitioners and managers.

David's family were given the opportunity to be involved in the review process. David's mother contributed her views and perspective.

All names in the reviews and in this summary have been changed to respect the privacy of David and his family.

2. Who was David?

David was a seven-week old baby at the time of his death, who resided with his mother and three older siblings. David's mother and father were separated, although father was sleeping at the family home at the time of his death.

The family had a long history of contact and support from many different organisations, with both parents having chronic substance misuse over many years. The family's

[1] Sudden Unexpected Death in Infants

home was cluttered and unclean with different professionals visiting the home regularly reporting the house was cold.

3. What is the key learning from the Reviews?

Areas where practice development has already taken place:

1. A Wakefield Safe Sleeping Standard has been developed which emphasises the importance of ongoing risk assessment about safer sleep. In addition includes specific risk of overlay assessment identifying modifiable factors which are known to contribute to SUDI.

2. Public Health have developed Safe Sleeping training alongside The Lullaby Trust[2]. This training will be available for all agencies to access to upskill professionals understanding of the association between co-sleeping and SUDI, increase confidence amongst those agencies who traditionally would not provide safe sleeping advice to support parents, and help to ensure parents understand the information they receive.

3. The criteria of Multi-Agency Pregnancy Liaison & Assessment Group (MAPLAG) has been reviewed to include pregnant women who are in recovery from substance misuse. Priority is given to women who are co-presenting with symptoms of low mood or mental health difficulties and/or showing evidence of disengagement.

Areas where practice development is required include:

1. **Safe sleeping being an area for agencies broader than health visiting and maternity** - recognising the danger of co-sleeping has implications for all agencies visiting homes with infants under six months old.

2. **Written information and advice about safe sleeping is not equally effective for all parents** - the high reliance by professionals providing SUDI advice to parents to act appropriately even when there were repeated occasions when unsafe practices were observed. More attention to how parents understand, retain and can act on the information is important and seeing where children are sleeping.

3. **Professionals developing and using focussed and respectful curiosity** – professionals did not feel able to ask to see the upstairs of the properties and therefore see where the children were bathed and slept. The condition of the exterior areas to the house did not provoke curiosity about the conditions where the children slept.

4. **Assessments being rigorous enough in terms of the investigatory process and age-related child development** – the assessments were not curious and aware of why parental history was critical and did not include all relevant professionals to give information and contribute to analysis. Assessments that were complete did not result in the level of Children Social Care involvement that

[2] The Lullaby Trust - www.lullabytrust.org.uk

was required along with other services. Tool kits and frameworks designed to help inform professional judgment about issues such as neglect or a child's attachment were not used.

5. **Seeing the world of the child through their eyes** - in enquiries, assessment and decision-making, reflecting upon and asking about the impact the behaviour a parent has on the child is important for a child of any age. Children who are too young to verbally communicate can still provide important information to professionals with an understanding of age-related child development, through observing the interaction of parents with their children and show curiosity.

6. **Computer-generated prescriptions for controlled drugs** - which have become normal prescribing practice makes the actual process of prescribing opioids much easier and opioids may be entered onto repeat prescribing systems. Any drugs with the potential to sedate should be prescribed with caution and appropriate advice given to the parent/s or carer/s of infants and young children.

7. **Ensuring primary care services have effective arrangements to identify and respond to neglect** - Practices should have robust procedures for handling incoming correspondence and notifications from other agencies, to ensure that any safeguarding information is recorded, and responded to, appropriately.

8. **Poverty and social deprivation** - are overrepresented in the profile of children dying from SUDI. This does not mean those factors cause SUDI but do need to be factored into assessment and are relevant to a wider consideration of children's welfare and resilience. There was no recorded evidence of this being considered and explored in assessments with the families.

9. **Developing relationships of support for families** - high levels of complex need and vulnerability are less likely to be understood enough through single or time-limited home visits. Professionals who have the time to develop an understanding of underlying history and issues and to build a relationship of trust are more likely to provide effective help.

10. **Early Help Assessment and plans** - should include specific reference to safe sleeping arrangements and incorporate the use of the neglect toolkit.

4. Next Steps

The findings from this review has been disseminated across those agencies in Wakefield involved with supporting children and families so that the lessons can be widely learned.

An action plan to the key learning points of the review has been developed and monitored by the Child Safeguarding Practice Review and Learning and Development Sub-groups of WSCP.

5. References

HM Government (2018) Working Together to Safeguard Children