7 Minute Briefing: Safer Sleeping re Child Cypress

Date: July 2023

1. Background

This Rapid Review relates to the death of a five-and-a-half-month-old baby.

Mum reported that her baby would not settle in a Moses basket and so Mum, Dad, the baby and one sibling would normally sleep on the sofa together with the baby at Mum's feet (top and tail).

During the night she fed her baby with no known difficulties.

Parents reported that they woke in the morning and found their baby unresponsive and not breathing.

Paramedics attended and took the baby to hospital to continue resuscitation but was pronounced deceased shortly after being admitted.

2. Context

Mum and her children have been known to Surrey County Council for 7 years since they moved into the area, and Mum appeared to be the sole carer for her four other children, including one with additional needs.

The baby and her siblings were of mixed heritage and had different Fathers. The siblings had been subject to several Child and Family Assessments, as well as Section 47 enquiries. Police had been frequently called to the home due to a number of allegations including a neighbour raising concerns of children being left home alone.

A few years previously the GP had referred Mum to the Perinatal Mental Health Service (PMHS) after identifying low mood and suicidal thoughts, but she was discharged due to non-engagement.

In July 2022 a further referral to PMHS was received but mum continued to not engage. Mum's mental health deteriorated following the birth of her fifth child, and together with concerns about the children's wellbeing, the most recent CIN plan focused on Mum and action for the older siblings, with no reference to the baby other than observations that they were clean, asleep or happy during visits.

3. Key lines of enquiry

Mum cancelled antenatal appointments booked with the Health Visitor; was not at home for the rescheduled visit and didn't answer the Health Visitors phone calls.

She gave birth prematurely, and therefore she didn't receive an antenatal service from the Health Visitor team. Subsequently the Health Visitor discussed safer sleep at the four contacts that were successfully achieved and observed safer sleep practice and the provision of a Moses basket.

Although every opportunity was taken to discuss safer sleeping, her baby was at an increased risk due to her prematurity. Bottle feeding is associated with an increased risk of Sudden Infant Death Syndrome (SIDS).

4. Key lines of enquiry continued

Disengagement by Mum with the Health Visitor caused a significant delay in opportunities to review her baby's health, growth and development, which hindered a further opportunity to review and repeat safer sleep advice and prevented further exploration around the parental relationship and other family health needs.

Although the Health Visitor attempted several times to contact Mum, an opportunist home visit or planned joint visit with the Social Worker may have been more successful, however it had been difficult to reach the Social Worker, so this wasn't arranged.

5. Key lines of enquiry continued

The family moved house when the baby was less than a month old and it seemed that multiple adults were in and out of the family home. This may have further increased the challenge for parents to understand the risks and follow safer sleep advice as the home environment and persons present was unpredictable and ever-changing.

In addition to moving to a new house, it is apparent that the family had moved addresses numerous times, including relocating between various counties and boroughs. This would have been challenging for the family and children to cope with.

Frequent moves can lead to a loss of historic information about the family when records are not transferred in a timely way between agencies or if verbal handovers are not provided, as appeared to be the case this family.

6. Learning

1. Practitioners should tailor advice on Safer Sleeping to each child and family's individual circumstances, understanding the increased risks and focusing on how to address them with the family.

Verbal information and sharing of the Lullaby Trust be given to families, but consideration should also be given to reinstating a leaflet on safer sleeping for babies, as some parents might not have access to the internet. Safer-Sleep-7-Minute-Briefing-Dec-2022

Whilst there may be no observation of unsafe sleep practices by practitioners, the pressures of caring for other children, especially if they have additional needs, may contribute to a parents' decision making and care of their baby, so it's important to consider the contextual factors within the family dynamic.

7. Learning continued

2. For professionals to routinely review a family's history of addresses to ensure records are shared between all relevant agencies.

3. For professionals to fully explore details of household members and contact arrangements as a contributing factor in the analysis of the children's daily lived experiences.

4. Consideration of Joint Visits to a family, especially if one agency is struggling to engage with a family.

5. It is important that any professional disagreements are addressed and resolved as quickly as possible, so that children and their families get the help they need, as quickly as possible. The Surrey FaST (Finding Solutions Together) resolution process is our way of enabling this. For FaST enquires please email partnership.escalation@surreycc.gov.uk

6. Professional Curiosity to always be considered when parents aren't engaging and the subsequent impact of their lack of engagement on the lived experiences of their children.

7. The engagement of fathers is an important aspect to consider. CSH are running a pilot called ***Dads Matter***. Dads Matter Surrey support dads to have the best possible relationship with their families. They work closely with other professionals within Surrey and nationally to support dads in the first 1001 days of their parenting journey. For further information please visit the website Dadmatters.org.uk or email dadmatters@homestarthost.org.uk. Training is also provided via **Olive**: ***Engagement of Fathers and significant Males in Child Protection*** surreycc.gov.uk/scsa or email surreychildrens.academy@surreycc.gov.uk