Kent Safeguarding

children multi-agency Partnership

local Child safeguarding practice review (lCSPR)

BABY ‘T’

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**Table of Contents**

|  |  |  |
| --- | --- | --- |
| **1.** | **INTRODUCTION** | 3 |
|  | 1.1 Trigger for Local Child Safeguarding Practice Review (LCSPR) | 3 |
|  | 1.2 Purpose & scope | 3 |
|  | 1.3 National thematic review brief summary | 4 |
|  | 1.4 Why benchmark, using the case of Baby T? | 4 |
|  | 1.5 Source material and methodology | 4 |
|  | 1.6 Contribution of professionals | 5 |
|  | 1.7 Family engagement | 5 |
| **2.** | **THE NATURE AND CIRCUMSTANCES OF SUDI IN FAMILIES WITH CHILDREN AT RISK** | 5 |
|  | 2.1 Context | 5 |
|  | 2.2 Co-sleeping | 6 |
|  | 2.3 Parental alcohol or drug use | 6 |
|  | 2.4 Parental mental ill-health | 6 |
|  | 2.5 Evidence of neglect | 7 |
|  | 2.6 Domestic violence | 7 |
|  | 2.7 Over-crowding/poor housing | 8 |
|  | 2.8 Parents previous criminal conviction | 8 |
|  | 2.9 Parent Care Leaver | 8 |
|  | 2.10 Young parents | 8 |
|  | 2.11 Summary | 8 |
| **3.** | **THE EFFECTIVENESS OF LOCAL ARRANGEMENTS FOR PROMOTING SAFER SLEEP AND REDUCING THE RISK OF SUDI** | 8 |
|  | 3.1 Context | 8 |
|  | * 1. Preventative work at population level – evidence from the national review | 8 |
|  | 3.3 Protective work with families with additional needs and situational risks – appreciative inquiry in the case of Baby T | 9 |
|  | 3.4 Supporting families and improving engagement | 11 |
| **4.** | **ADDITIONAL INFORMATION EMERGING DURING THE LCSPR** | 12 |
| **5.** | **FINDINGS** | 12 |
|  | 5.1 Identifying and describing factors limiting the ability to challenge parents | 12 |
|  | 5.2 Defining ‘good enough’ home conditions and the impact of Covid on service delivery | 12 |
|  | 5.3 Appreciating the children’s ‘lived experiences’ | 13 |
|  | 5.4 The difficulties in evaluating parental mental health and/or substance misuse | 13 |
|  | 5.5 Father’s need for support | 13 |
| **6.** | **THE PREVENT AND PROTECT MODEL** | 14 |
|  | 6.1 National review recommendations | 14 |
| **7.** | **RECOMMENDATIONS IN RELATION TO THE PREVENT AND PROTECT PRACTICE MODEL** | 14 |

1. **INTRODUCTION**
   1. **Trigger for Local Child Safeguarding Practice Review (LCSPR)**

1.1.1 Soon after midnight, some 2 weeks before Christmas 2020, South East Coast Ambulance (SECAMB) Service received a 999 call from T’s mother[[1]](#footnote-1) to report that her then 7-week-old son was not breathing. An ambulance attended and its crew administered cardio-pulmonary resuscitation (CPR). T was taken to Medway Hospital where efforts to revive him continued for a further 90 mins before he was pronounced deceased.

1.1.2 At the time of his death, T and siblings, aged 5 and 2 (all White-British) were open to Kent’s Integrated Children’s Services (ICS) and an Early Help Unit (EHU) had recently initiated an ‘Early Help Assessment’. An earlier referral from what was then called the Mother & Infant Mental Health Service (MIMHS)[[2]](#footnote-2) received at the end of November 2020, noted a deterioration in Mother’s mental health, and concerns about consumption of alcohol and cannabis use. A ‘safety plan’ predicated on Father assuming responsibility for the care of the children if his wife consumed alcohol was agreed.

1.1.3 Attending police officers were told T was co-sleeping with his mother who had drunk some alcohol. Both parents were arrested on suspicion of neglect and causing/allowing the death of T. Bail conditions were imposed to prevent contact with the older children who were cared for by members of the extended family. Following a criminal investigation, the Crown Prosecution Service concluded in August 2021 that insufficient grounds existed for any prosecution. At parallel family proceedings, the Court determined T’s siblings could (subject to a Supervision Order) return to the care of their parents.

* 1. **Purpose & scope**

1.2.1 On 19.01.21, Kent’s Rapid Review Group concluded T appeared to have died as a result of abuse or neglect but that the safety of siblings was assured by the immediate steps taken. Whilst agency-specific learning was identified and actions initiated, the local Safeguarding Children Partnership found that the case satisfied the criteria within ‘Working Together to Safeguard Children’ 2018 and there *was* potential further learning to be derived. That view was questioned by the national ‘Child Safeguarding Practice Review Panel’ in a response provided in February 2021. Its declared opinion was the local Partnership might instead ‘benchmark’ i.e. compare and contrast the responses made to the family with the government July 2020 guidance in its paper ‘Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm.’ [[3]](#footnote-3)

1.2.2 Having considered the views of the national panel and after a delay in consequence of Covid constraints and a local re-organisation, a Local Child Safeguarding Practice Review (LCSPR) *was* subsequently commissioned in September 2021. What was then known suggested the following issues might be of local relevance to the period of review: 01.01.20 to date of death in December 2020.

* The importance of professional curiosity and avoidance of optimism when ‘supporting’ families (rather than conducting investigations), especially if either parent has a mental health history
* Need for the child’s needs to remain paramount
* Importance of understanding the role of the father

### **National thematic review brief summary**

1.3.1 The review sets out its relevance stating, “Infants dying suddenly and unexpectedly represent one of the largest groups of cases notified to the Panel… they occur in families who are particularly vulnerable and each one is a devastating loss for the family.” CSPRP (2020) p.6

1.3.2 It cites a shift towards tragic SUDI cases happening “predominantly in families from deprived socio-economic backgrounds” (CSPRP, 2020, p.4) whose circumstances increasingly demonstrated wider risk factors often associated with abuse and neglect.

1.3.3 The review seeks to better understand the circumstances in which these babies are dying, why parents make the choices they do about care giving and sleeping arrangements, and how practitioners work with families whose children have been identified as at risk.

1.3.4 It informs the development of a ‘prevent and protect’ model of service delivery with the aim of reducing the risk of SUDI and improving children’s health, safety, and development more widely.

**1.4 Why benchmark, using the case of Baby T?**

1.4.1 Information provided to the KSCMP as part of the rapid review process suggested the context and circumstances of Baby T’s death are similar to those families considered as part of the national review. It was envisaged a benchmarking exercise would afford the KSCMP an opportunity to review current delivery of safer sleep messages, and wider child safeguarding, by professionals in Kent, and what more needs to be done in line with the national review recommendations to further reduce the risk of SUDI, particularly for the most vulnerable families.

1.4.2 It is important to acknowledge the title of the national review suggests its relevance to children considered ‘at risk of significant harm.’ Its in-depth fieldwork of 14 of the notified cases did however consider the cases of two families who were only known to universal services at the time of the babies’ deaths. In the case of Baby T and at the time of his death, the children in the family were not considered ‘at risk of significant harm,’ but recently opened to Tier 3 intensive support from Kent’s Integrated Children’s Services, Early Help Unit.

**1.5 Source material & methodology**

1.5.1 This report was developed from information supplied by:

* Kent Police
* Kent & Medway NHS & Social Care Partnership Trust (KMPT)
* South East Coast Ambulance Service (SECAMB)
* Kent Community Health NHS Foundation Trust (KCHFT)
* Kent Integrated Children’s Services (ICS)
* Medway Foundation Trust (MFT)
* Maidstone & Tunbridge Wells NHS Trust (MTW)
* Kent & Medway Integrated Care Board (ICB)

1.5.2 The authors were supported at remote panel meetings by representatives from the above organisations.

### 1.5.3 The review was conducted between October 2021 and June 2022. Thanks are due to those who committed time to reflect upon and discuss at (remote) meetings, their individual involvement or that of their Service.

### **1.6 Contribution of professionals**

### 1.6.1 The local Partnership determined the LCSPR should be conducted using an ‘appreciative inquiry approach’ - its primary aim being to help understand, define and celebrate good multi-agency safeguarding practice, as opposed to focusing on what went wrong and attributing blame. The LCSPR sought to evaluate the extent to which service delivery satisfied the aspirations of the national SUDI guidance. A multi-agency consultation event was convened to discuss the inherent challenges of recognising and distinguishing between universal needs of the parents of all new-borns and those (of varying levels of importance and urgency) that apply to a minority.

### **1.7 Family engagement**

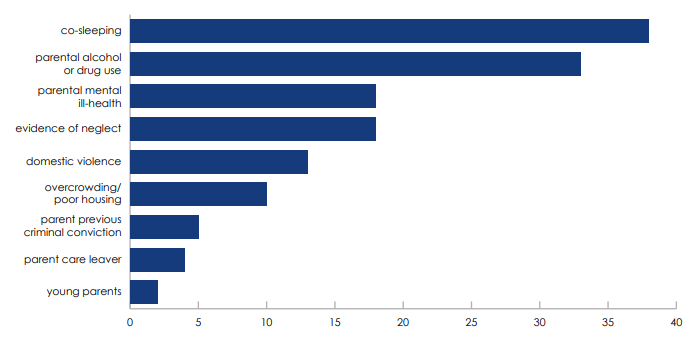
### 1.7.1. Mindful of the possibility of criminal action, an invitation for parental involvement was deferred. Following confirmation there was to be no prosecution, the parents were invited to contribute and a meeting at the family home was held. Despite the grief they continue to experience and a perception some services let them down, they offered clear and convincing responses to a range of sensitive subjects addressed during the interview. They also referred to some events not captured in the material supplied to the LCSPR.

### **2. THE NATURE AND CIRCUMSTANCES OF SUDI IN FAMILIES WITH CHILDREN AT RISK**

**2.1 Context**

2.1.1 Drawing upon data from 40 cases, the national study identified the majority of babies who died unexpectedly were less than 3 months old (63%) and were male (53%). Baby T fitted this group, being 7 weeks old at the time of his death. The national review noted there was no suggestion parents had intended harm to their babies and were as loving as any other parents. This is also true in the case of Baby T.

2.1.2 The wider risk factors identified in the national review cases are demonstrated below:



**2.2 Co-sleeping**

2.2.1 The situational risk co-sleeping presents was recorded in 38 of the 40 cases in the national review. On the night of his death, Baby T was placed in a super-king size bed to sleep between his 2-year-old sibling and his mother. The family did own a Moses basket, which parents reported to professionals he routinely slept in. It is unclear the extent to which this was the case, or if his sleep in Mother’s bed that night was ‘out of routine.’

**2.3 Parental alcohol or drug use**

2.3.1 Evidence ofMother’s alcohol and drug use over a number of years suggests a predisposition to vulnerability and risk. It was a contributory factor in historic criminal behaviour cited below.

2.3.2 In the year prior to Baby T’s birth, a GP recorded a diagnosis of Alcohol Dependence Syndrome. In 2020 Mother was referred to substance misuse services in relation to her alcohol and cannabis use.

2.3.3 During pregnancy with Baby T, both Mother and Father were offered smoking cessation services. Father completed the programme, with Mother declining it. Agency reports subsequently refer to Father ‘smoking outside’ following the birth of Baby T *and* the house smelling of smoke.

2.3.4 A safety plan completed with parents by what was then ‘MIMHS’ regarding safe caregiving for the children given Mother’s mental health and substance use was predicated on the belief Father did not drink alcohol. Information gathered as part of this review indicates Father did drink alcohol.

2.3.5 Alcohol use also presented a situational risk on the night in question, with Mother having consumed wine before falling asleep. An empty wine bottle and a 3-litre wine box was observed by Police on the bedside table during their attendance to a report of Baby T’s cardiac arrest. Mother regularly used cannabis and said she may have smoked it on the night of Baby T’s death.

**2.4 Parental mental ill-health**

2.4.1 Prior to the pregnancy and birth of Baby T,clinical records suggest Mother’s diagnoses included Borderline Personality Disorder, anxiety, depression, and a sleep disorder, presenting a knowable predisposition to vulnerability and risk. There is evidence in her history of **i**ntentional self-harm and overdose.On several occasions in her past, Mother changed her own dosages of prescribed medication without any medical supervision, putting her at risk of accidental overdose.

2.4.2 Records also suggest Mother has shared with professionals that she had an eating disorder and Obsessive Compulsive Disorder which for her manifests in a compulsion to clean and tidy (see ‘Evidence of neglect’ section below).

2.4.3 In the autumn of 2020, Mother reported to a mental health worker that Father’s physical health challenges were causing her to feel increased stress. (He had recently suffered a pulmonary embolism.)

2.4.4 At the time of Baby T’s death, Mother was open to MIMHS, a specialist mental health service, and had accessed seven of ten scheduled appointments (a combination of telephone and in person).

**2.5 Evidence of neglect**

2.5.1 In the agency reports provided, there is some evidence to suggest neglect of the children in relation to the condition of their living environment over several years. This was knowable, but not necessarily known to all those involved immediately prior to Baby T’s death.

2.5.2 Cluttered home conditions were first noted in records during 2018. Later, in the weeks leading up to Baby T’s death in 2020, home conditions were recorded by one agency as dirty, and with a stained carpet that had food crumbs and other debris on it. The house reportedly smelled of smoke and urine. A separate agency recorded an infestation of fleas, though parents subsequently disputed this. This information does not corroborate Mother’s claims that she was obsessively cleaning and tidying to manage her OCD.

2.5.3 Police attending the call alerting them to Baby T in cardiac arrest recorded home conditions as very dirty, unhygienic and unkempt, with a dead mouse found in one room and rubbish bins and surfaces reportedly full.

2.5.4 In a separate issue relating to possible neglect, in June 2020 there was a 4-day delay in presentation of Baby T’s 2-year-old sibling to medical professionals following an unwitnessed accident. Other childhood accidents were all responded to in a timely and appropriate way by parents.

2.5.5 Following Baby T’s birth, hospital staff recorded ‘bizarre’ behaviour, in that Mother commented to them quite casually how she dropped Baby T, something she reported had also happened with his older siblings when they were babies.

**2.6 Domestic violence**

2.6.1 Pre timescales of this review, in 2015 a verbal altercation between Baby T’s parents was attended by Police. A Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment recorded ‘standard’ risk and a Domestic Abuse Notification was submitted to Kent Children’s Services.

2.6.2 There is no suggestion the domestic abuse was a factor in the circumstances that led to the death of Baby T and there were no other reports of domestic abuse in the reports provided to the review.

**2.7 Overcrowding/poor housing**

2.7.1 Overcrowding and poor housing were not cited as factors of concern in Baby T’s case, however, home conditions were, as cited above in ‘Evidence of neglect.’

**2.8 Parent previous criminal conviction**

2.8.1Historic information provided by Police reveals that from 2000-2004 an inebriated mother (then a young adult) was involved in 4 violent incidents. She was imprisoned for 1 of 2 instances when conduct was defined as ‘grievous bodily harm’. This information was knowable to agencies and indicated a predisposition to risk.

2.8.2 Father was only known to police for historic driving offences.

**2.9 Parent care leaver**

2.9.1 The review was not in receipt of any information suggesting either parent was a care leaver.

**2.10 Young parents**

2.10.1 Mother and Father of baby T did not fall into this category, being 34 and 38 years of age respectively at the time of Baby T’s death.

**2.11 Summary**

2.11.1 When considering the most prevalent predisposing and situational factors identified by the national review, it may be concluded the family circumstances of Baby T did indicate he was at higher risk of SUDI than the general population of babies in England and Wales. Of the 9 identified characteristics, at least 5 can be evidenced in his case (if the one domestic abuse incident reported in 2015 is discounted).

2.11.2 It is important these predisposing and situational factors are widely recognised by professionals across the Kent Safeguarding Children Multi-Agency Partnership to effectively assess risk of harm (including cumulative risk) in families being supported. Embedding this knowledge to underpin local arrangements may support the Partnership’s ambition to further reduce the risk of SUDI in vulnerable families.

1. **THE EFFECTIVENESS OF LOCAL ARRANGEMENTS FOR PROMOTING SAFER SLEEP AND REDUCING THE RISK OF SUDI**
   1. **Context**

3.1.1 The national review identifies aspects of local arrangements for promoting safer sleep and reducing the risk of SUDI. It explores preventative work at population level, protective work with families with additional needs and situational risks, and support for families to reduce risks and improve engagement.

* 1. **Preventative work at population level – evidence from the national review**

3.2.1 National sleep advice for all parents produced by the Lullaby Trust is based on the principles that safest sleep during infancy is achieved when in the first six months of life, a baby is placed on their back to sleep, day and night, separately from others, in a cot or Moses basket, in the same room as the caregiver(s).[[4]](#footnote-4)

3.2.2 The national review found Lullaby Trust materials are widely used across the country, and further, some localities developed additional materials to address relevant contexts.

3.2.3 ‘Out of routine’ found some parents considered safe sleep messages to be inconsistent, with associated materials varying in quality. What it did not highlight however, is that despite the Lullaby Trust’s core principles and advice, there is a section on its website offering guidance on how to co-sleep ‘safely.’ This might help explain why some parents feel the messages given to them are inconsistent.

3.2.4 The review identified pregnancy as a ‘reachable moment,’ presenting a valuable opportunity for healthcare professionals such as midwives and health visitors to deliver the safer sleep message and identify potential predisposing or situational factors likely to indicate vulnerability and the need for more targeted support.

3.2.5 During fieldwork, professionals acknowledged the dangers of becoming desensitised to risk when working in areas of high deprivation. This is particularly pertinent given the SUDI shift towards families from deprived socio-economic backgrounds.

* 1. **Protective work with families with additional needs and situational risks – appreciative inquiry in the case of Baby T**

*Ante-natal period*

3.3.1 Early in her pregnancy, Mother disclosed to midwives during the booking in process, information about her mental health, alcohol and cannabis use prior to pregnancy, smoking, and criminal history. This prompted the timely completion of a ‘Concern & Vulnerability’ (C&V) form, endorsing the national review’s assertion that pregnancy is a ‘reachable moment’ during which health professionals are well positioned to identify risk.

3.3.2 Unfortunately, due to an administrative oversight, the C&V form was not sent to Midwifery Liaison (MTW) for distribution to the Safeguarding Midwife, GP and Health Visiting Service, though it was later received by Community Midwives once T was born and discharged from hospital.

3.3.3 Both Mother and Father were referred to a smoking cessation service. This not only evidences recognition of the risks associated with pregnancy, but also consideration of Father’s needs and the possible impact of his behaviour on the baby in-utero and post-birth, and on the older children.

3.3.4 At around 26 weeks gestation, Mother was offered an appointment by the Lead Perinatal Mental Health Midwife. Perinatal Mental Health Midwives can provide support focussing solely on maternal mental health, and in this case, facilitated the identification that Mother required a more specialist service. A referral to MIMHS was completed. This evidences a further ‘reachable moment’ during which Mother’s level of vulnerability was recognised and acted upon.

3.3.5 Mother was offered an assessment by MIMHS within allocated timeframes and the results of the assessment were shared with the GP, Midwife and Health Visitor. Appropriate sharing of information helps professionals provide a holistic, wrap-around service and was good practice in this case. What is unclear however, is *if* or *when* those the report was shared with read it.

3.3.6 The Health Visiting Service discussed Mother’s pregnancy with her at another of her children’s developmental reviews (undertaken virtually due to COVID restrictions at that time). They planned with her to complete a ‘New Birth Visit’ alongside a speech review for the older child in 2-3 months. The Health Visiting Service also made two attempts to make ante-natal contacts but were unsuccessful due to Mother being in hospital giving birth.

*Post-natal period*

3.3.7 At the New Birth Visit made by the Health Visitor, parents were advised not to tilt T using a pillow as they were doing and were given leaflets produced by the Lullaby Trust. This corroborates the national findings that such materials are widely used and is evidence the Health Visitor offered specific guidance in relation to a safe sleep environment. There is some suggestion Parents reported to be replicating what they did with their two older children when they were babies.

3.3.8 There is evidence from the records that safe-sleep advice was also given to Mother during a home visit undertaken by a Midwife when T was 4 weeks old. Advice regarding attachment and feeding was also given during home-visits by the Midwifery Service, which afforded an opportunity for the home to be seen during lockdown restrictions arising from the covid pandemic. Mother was also advised MIMHS was trying to contact her, evidencing information sharing between organisations and multi-agency delivery of support.

3.3.9 During a face-to-face visit at the family home when Baby T was 4-weeks old, Mother disclosed to a MIMHS worker she continued to smoke cannabis and drink alcohol. In response, the worker undertook a safeguarding consultation with a KMPT Perinatal Social Worker and the decision was made to initiate a Request for Support (RFS) with a view to Early Help intervention. A safety plan was also agreed with both Mother and Father, stating that Father would care for the children if Mother consumed alcohol. The risks around co-sleeping was also discussed.

3.3.10. This MIMHS contact evidences a clear response to the identification of risk and consideration for what other types of support might have been needed to enable this family to thrive.

3.3.11 The RFS was received the same day and allocated to an Early Help Unit (Tier 3 support). Direction was given to the allocated Senior Early Help Worker to contact the family, understand how wider family and friends can support, contact the referrer and other professionals supporting the family, gain the voice of the children to understand their lived experiences and to complete a family genogram and timeline to explore any significant changes and events. Direction was also given to explore the concerns raised regarding Mother’s alcohol use and to clarify the safety plan for the children. Signposting to the Forward Trust[[5]](#footnote-5) and Mother’s local children’s centre if appropriate were also suggested.

3.3.12 By this point, there is evidence in this case to suggest a model of service delivery aiming to not only reduce the risk of SUDI, but also improve the health, safety and development of the children more widely was under way, in line with the ‘prevent and protect’ model proposed by the national review.

3.3.13 At his 6-week review, the Health Visitor reiterated safer-sleep advice and noted cluttered home conditions. Father’s engagement is also noted during this appointment in relation to discussions about feeding.

3.3.14 The allocated Senior Early Help Worker contacted MIMHS and the Health Visiting Service to discuss current concerns. They also contacted the family, initially speaking with Father. During this telephone call, again, safe-sleep advice was given and the risks around co-sleeping emphasised. Father reassured the Senior Early Help Worker that T slept in a Moses basket, and he would assume responsibility for the care of the children when Mother was drinking alcohol. An initial face-to-face visit was later booked with Mother over the telephone.

3.3.15 At this stage, professionals in direct contact with the family were proactively triangulating information and beginning to corroborate each other’s perspectives of what life was like for them.

3.3.16 The initial home visit between the Senior Early Help Worker and the family did not go ahead, as Baby T tragically passed away before the scheduled visit.

* 1. **Supporting families and improving engagement**

3.4.1 In line with the national review against which this case is benchmarked, it is documented T’s parents were delivered the safe-sleep message on multiple occasions during virtual and home visit conversations. What the national review suggests however, is that parents do not always find such conversations ‘meaningful.’

3.4.2 Information provided to this review does not make clear how, or even if, parental views, insight and understanding for the need to provide a safe sleeping environment were checked by professionals, though T was observed on one occasion to be sleeping in a Moses basket as per safer-sleep guidance.

3.4.3 The national review suggests safe sleep promotion needs better integration into wider assessment of need and risk, and safety goals in subsequent plans should be explicit.

3.4.4 What this benchmarking review tells us is that evidence of disguised compliance was not necessarily incorporated into assessment of risk and subsequent planning. For example, in the ante-natal period, Father was recorded as having ‘completed’ a smoking cessation programme, later to report ‘smoking outside,’ and the house was observed to be smelling of smoke. The safety plan agreed with parents by MIMHS, and checked by Early Help, was predicated on the understanding Father did not drink alcohol, a fact he confirmed to the Senior Early Help Worker, though he occasionally did. Also, he would assume care of the children should Mother be drinking alcohol, which he did not on the night Baby T passed away. Father confirmed to the Senior Early Help Worker that Baby T slept in a Moses basket, though on the night of his death he was in bed with his mother and older sibling. A wider assessment of need and risk may have identified a historic overreliance on what Father was reporting and agreeing to and corroborated this with evidence of what he was doing practically within the household.

3.4.6 Wider assessment of need and risk did not appear to directly link home conditions in this case to the risk of SUDI. Information provided to this review offered differing, subjective accounts regarding the state of the environment and little to consider it in the context of safer sleep. The family sleeping environment was not observed by professionals, despite one recording all family members were sleeping in the same room. It would also appear there was a lack of challenge to Mother’s perception she was obsessive about cleaning, which would have likely made links with her mental health and its impact on the children.

**4. ADDITIONAL INFORMATION EMERGING DURING THE LCSPR**

4.1 During the independent author’s meeting with parents, it was revealed that on the basis of concerns about their baby, they presented T to the GP Practice where they were reassured the symptoms were associated with an umbilical hernia and required no intervention. 2 days later (and 4 days before T died) the parents sought a consultation for their baby’s reported ‘crankiness’ in the previous 2/3 days. In consequence of a lack of available appointments, (reportedly not a Covid-related constraint) only contact by phone was achieved. The parents feel this was potentially a missed opportunity. In the context of the national review, it may also offer an insight as to why Baby T may have been sleeping in his mother’s bed, a situation that may have been ‘out of routine’ due to him presenting as unwell

**5. FINDINGS**

* 1. **Identifying and describing factors limiting the ability to challenge parents**

5.1.1 Based upon available records and discussions with relevant professionals and the parents, it would appear the following constraints singly and in combination, served to limit professionals’ ability to challenge parental accounts (and to contextualise observations):

* Insufficient capture and exchange of information across agencies (though the extent of this was unremarkable and *no* indication of any intentional withholding has been found)
* Insufficient professional curiosity about incomplete or contradictory parental accounts e.g. reports of obsessive cleaning versus observed state of the home and exploration of both parents’ alcohol use
* Reduced confidence or rigour when a professional is offering *support* rather than conducting a more focused *investigation* of concerns or allegations

**5.2 Defining ‘good enough’ home conditions and the impact of Covid on service delivery**

5.2.1 The relative lack of detail within records maintained before the trigger incident, render it hard to be confident about the level of cleanliness or orderliness that prevailed in T’s home. Amongst the issues of potential relevance to all the children were:

* The smell recorded by the allocated health visitor of urine and cigarette smoke
* The extent and nature of what was described by midwives as a ‘cluttered but not dirty’ environment (police officers’ description at the time of the trigger incident painted a more negative picture – the author’s post-event visit reinforces the observations of Health practitioners)

5.2.2 In consequence of the decision, within the context of Covid-restrictions, to limit the health visiting service to ‘Universal’, opportunities to observe and potentially challenge the home environment were potentially limited.

**5.3 Appreciating the children’s ‘lived experiences’**

5.3.1 At times, the records of visiting professionals omitted the whereabouts of one or other child. Whilst there may have been direct engagement with T’s older siblings, it is not apparent from the records provided.

### 5.3.2 Given reported developmental difficulties of T’s older sibling, exploring the responses of both older siblings to T’s birth could have been of value.

5.3.3 Though the existence of a ‘Moses Basket’ was usefully confirmed in December 2020, the extent/frequency of its use as opposed to sharing a bed with either parent remained un-recorded. Author’s discussions with the parents (and their recollection of comparable ones with HV1) suggests an openness to challenge and discussions about alternative approaches to establishing a routine for their new-born.

### 5.3.4 As highlighted in the ‘Out of Routine’ report, more authoritative practice might have more rigorously gathered, triangulated and debated observations about the risk correlates for T (as per section 2) and his siblings.

### **5.4 The difficulties in evaluating parental mental health and/or substance misuse**

### 5.4.1 Inevitably more difficult to determine over the phone, the nature and extent of Mother’s mental health needs and of her use/misuse of alcohol could have been better addressed had there been more substantial liaison between health visitor, GP Practice and others i.e. greater triangulation as promoted in the ‘Out of Routine’ report.

### 5.4.2 Mother’s reference during her initial ante-natal care of an eating disorder (though now much diminished according to her) was overlooked in any subsequent contacts. The self-reported level of maternal alcohol consumption varied significantly across agencies leaving its actual contribution to any unreliability in caring for new-born T and additional risk of SUDI, uncertain. Recognition of the low level of alcohol by volume and patterns of its consumption could have informed useful discussions with parents.

### 5.4.3 Although T’s immediate well-being was assured at the time, Mother’s casual reference to having dropped T and (when they were babies) his older siblings would have justified some further thought.

### **5.5 Father’s need for support**

### 5.5.1 Acceptance of Father’s assurances about his capacity and availability to ensure adequate care of his children in the event Mother consumed alcohol left unexplored his own physical and psychological needs. The possibility of his health impacting upon the family is raised by Mother’s report to her mental health worker of ‘ongoing stressors’ associated with his (significant) health needs and the incidents of Autumn 2020 when Father was seen by ambulance and hospital staff respectively. A collation of what was known across the network about Father reinforces his value as a supporter of his partner and carer for the children.

### **6. THE PREVENT AND PROTECT MODEL**

### **6.1 National review recommendations**

### 6.1.1 The national review proposes a practice model recognising a continuum of risk of SUDI, with support reflecting the differing needs of all families, including those with identified, additional vulnerabilities. The proposed framework suggests a basis from which local safeguarding partners can work with commissioners and providers to implement flexible support for families, to reduce instances of SUDI.

### The key features of the practice model are:

### Robust commissioning to promote safer sleeping within a local strategy for improving child health outcomes

### Multi-agency action to address pre-disposing risks of SUDI for all families, and with targeted support for families with identified additional risks

### Differentiated and responsive multi-agency support and challenge with families to promote safer sleeping in the context of safeguarding concerns and other situation risks

### Systems and processes that support effective multi-agency practice across the continuum of risk of SUDI

### **7. RECOMMENDATIONS IN RELATION TO THE PREVENT AND PROTECT PRACTICE MODEL**

### Practice model: Robust commissioning to promote safer sleeping within a local strategy for improving child health outcomes

**Recommendation 1)** Kent & Medway Integrated Care Board,to review existing ‘Reducing the Risks to Babies’ NICE Guidance with a view to developing a local policy in collaboration with the KSCMP Executive Board, for multi-agency professionals completing assessments where there are young babies in the family. Policy to be implemented across the partnership.

### Practice model: Multi-agency action to address pre-disposing risks of SUDI for all families, and with targeted support for families with identified additional risks

### **Recommendation 2)** KSCMP Business Team to produce a briefing paper for multi-agency circulation that highlights the predisposing and situational risks of SUDI and appropriate guidance and referral pathways.

### Practice model: Differentiated and responsive multi-agency support and challenge with families to promote safer sleeping in the context of safeguarding concerns and other situation risks

**Recommendation 3)** KSCMP Business Team to lead an audit of current understanding and use of motivational interviewing across partner agencies and explore what training is already being offered. Consider if and how motivational interviewing should be incorporated into the KSCMP multiagency training package.

**Recommendation 4)** Promote the ‘Clutter Scale’ assessment tool advertised by the Kent and Medway Safeguarding Adults Boardacross the partnership.

### Practice model: Systems and processes that support effective multi-agency practice across the continuum of risk of SUDI

**Recommendation 5)** Incorporate safer sleep arrangements into threshold guidance.

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1. The report for the Coroner supplied by Kent Police suggests instead that Father made the first call [↑](#footnote-ref-1)
2. MIMHS, since renamed the Perinatal Mental Health Community Service (PMHCS), specialises in the assessment, diagnosis and short-term care and treatment of women 18 and above who are affected by a moderate to severe perinatal mental health illness in the preconception, antenatal and postnatal period. [↑](#footnote-ref-2)
3. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf> [↑](#footnote-ref-3)
4. https://www.lullabytrust.org.uk/safer-sleep-advice/ [↑](#footnote-ref-4)
5. The Forward Trust support adults to overcome drug and alcohol problems. [↑](#footnote-ref-5)