Process and Background:

A review was commissioned in this case following the death of a child (Child A1) whilst in the care of a family member overnight.

Working Together to Safeguard Children 2015 (now Working Together to Safeguard Children 2018) set out requirements for Local Safeguarding Children's Boards to commission Serious Case Reviews of cases that meet set criteria.

Child A1, their mother and father were known to Early Help and Health Services in respect of ante and post-natal care.

The family member who had care of Child A1 at the time of the incident had two children were known to Children's Social Care in another local authority due to domestic abuse concerns, where alcohol was believed to be a risk factor.

Emerging Issues from the Review:

Safe sleeping arrangements – Child A1 was reported to be unsettled throughout the night and would not take their bottle. The family member tried to settle Child A1 in the travel cot provided by parents but later settled Child A1 on the side/corner of the couch. It is also important to note that the family member had consumed a quantity of wine. Alcohol consumption is a risk factor when co-sleeping and is a recurring key feature in safe sleep cases.

Consideration within child protection processes of other caring responsibilities and any potential risks - a key aspect of the review was to consider if Child A1's parents were aware of the ongoing child protection processes for the children of the relative who was caring for A1 and the concerns underpinning these processes. It was noted that the parents of Child A1 had been at a "Family Network Meeting" which aimed to share concerns with family members and develop a plan to reduce these risks.

Information sharing between health agencies – it was noted in the review that although a Special Circumstances Form was generated, there was no evidence that this was shared with health visiting services and there were no mechanisms for this to be shared with the allocated GP.

Want to find out more?

How can I learn more about the Serious Case Review?

The Serious Case Review report is available on the RBSCP website (www.rbscp.org)

Safe Sleep will be the first area of focus for Rochdale's "Keeping Baby Safe" Campaign. More information will be available on the RBSCP website once this campaign is formally launched.

You can also visit www.lullabytrust.org.uk for more information on Safe Sleep, including details of Safer Sleep week will take place from the 9th-15th March 2020.

What does this mean for me?

1. When working with families under Universal Services, am I considering other relatives/carers in the wider family who might be babysitting children

2. Am I aware of recommended safe sleep advice to reinforce key safe sleep messages to all family members who might care for children?

3. Am I sharing information with colleagues in other agencies to ensure they are as informed as possible about families they are supporting?

Recommendations:

1. Where a Special Circumstances Form is generated by midwifery services, this is shared by key agencies involved e.g. GP and Health Visitors.

2. Information sharing and discussion to take place routinely between midwifery and GP practices where issues are identified, concerns are raised in order to understand the holistic family circumstances.

3. Where parental alcohol and substance misuse are risk factors, practitioners are able to consider any other caring responsibilities for children including babysitting arrangements.

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