City of York
Safeguarding Children Partnership

7 POINT BRIEFING:
Baby Thomas - Learning from Practice

Baby Thomas - A Single Agency Learning Review

1. Who was Baby Thomas?

Baby Thomas died as a result of Sudden Unexpected Death in Infancy (SUDI) aged just 12 days. He was the third child born to the same parents. The couple's first child was born several years prior to Baby Thomas's birth but tragically died aged 2 months as a result of an infection. The couple's second child was 8 years old at the time of Baby Thomas's birth.

2. Relevant family history

Baby Thomas's mother had long standing issues with alcohol misuse which had contributed to her experiencing chronic physical health issues. She had previously been referred to substance misuse services by her GP, however she declined to engage with the service and was subsequently discharged. Both parents had experienced difficulties with their mental health and had accessed support via their GP.

The family had several supportive extended family members and friends who lived nearby.

3. Why was this Single Agency Review (SAR) undertaken?

At the Joint Agency Response Meeting (JARM), following Baby Thomas's death, it was agreed that there was no information to suggest that any acts of commission or omission by either the family or professional had contributed towards Baby Thomas's death. However, there was information that indicated there may be learning for health partners involved in the families care during the antenatal and immediate postnatal period. Therefore, the City of York Safeguarding Partnership endorsed the decision for a SAR to be undertaken.

4. What key practice areas were identified as part of the SAR?

- **Assessing the home environment:** Due to ongoing maternal physical health issues most of mother's antenatal care was undertaken at the local hospital, with minimal contact in the community or family home. The Health Visitor and the Community Midwife did undertake some home visits, however these took place at the maternal grandmother's address, at mother's request. Therefore there was no opportunity to assess any indicators of concern within the home environment or to fully explore where the new baby would be sleeping. Information at the JARM meeting identified that health practitioners who attended the family address on the night Baby Thomas died and the following day had a number of concerns regarding the home environment. They described seeing numerous empty lager cans and rubbish bags at the side of the property and scattered across the garden. They reported some rooms were unkempt and dirty. Of particular significance was the presence of several empty lager cans in the downstairs living areas and at the side of the parents' bed. There were multiple holes in the internal doors of the property.

- **Maternal alcohol use:** During antenatal and postnatal period Baby Thomas's mother received a good standard of clinical care, she attended all her antenatal appointments. During the initial 'booking appointment' Baby Thomas mother informed health practitioners she had stopped drinking alcohol as soon as her pregnancy was confirmed. Despite having a long history of problematic drinking this was accepted at face value without further exploration by any of the health practitioners involved in her care.
- **Parental mental health:** Individual health partners were aware of the difficulties both parents were experiencing with their mental health and that they were in receipt of appropriate services via primary care. However, this information was not fully explored with the parents or between health practitioners with regard to how this might impact on their parenting of Baby Thomas or his sibling.
- **Understanding the increased risk of SUDI:** During the antenatal and immediate postnatal period Baby Thomas's mother received appropriate information regarding the steps she and her husband could take in order to reduce the risks of SUDI. However, the increased risk of SUDI specific to the history of maternal alcohol misuse, parental mental health issues and possible risk associated with the home environment did not prompt a more in depth discussion and exploration with the parents.

5. What were the key learning points?

- Greater professional curiosity during the antenatal and immediate postnatal period would have supported health professionals to explore and understand the vulnerabilities for this family, in particular the risks associated with SUDI.
- There were missed opportunities to assess the home environment and therefore to fully understand the circumstances in which the family were living and possible risks for Baby Thomas and his sibling.
- Improved information sharing between health professionals could have resulted in a greater understanding of the challenges the parents were experiencing and how professionals could have worked together in order to support them.
- The prevention of SUDI should be seen through a safeguarding lens and as risks accumulate consideration should be given to were this sits on the safeguarding continuum.
- It is important that the possible risks associated with fathers and/or their vulnerabilities are considered as part of the holistic assessment of families.

6. The Voice of the Child

Although Baby Thomas was new born and only 12 days old when he died it remains important for professionals to ask themselves what the child would say if they were able. What would it be like to be a baby living in this household? What would the baby say needs to change to improve his safety and wellbeing?

7. Next steps for City of York Safeguarding Children Partnership:

- As well as taking forward the specific actions arising from this SAR, the CYSCP has agreed to work with NYSCP to develop a multiagency SUDI prevention model, in line with the 'Prevent and Protect' practice model advocated by the National Safeguarding Children Practice Review Panel.
- The model will support professionals from all relevant agencies to identify risks of SUDI and know how to respond with interventions differentiated to reflect the needs of the families.

Useful Resources:

For further information and advice please visit:

- Lullaby Trust
- City of York Safeguarding Children Partnership Threshold Document
- City of York and North Yorkshire Safeguarding Partnership's Managing Injuries to Non-Independently Mobile Guidance
- National Panel Thematic Review Sudden Unexpected Death in Infancy

Where do I go for further information?

Please visit the CYSCP website for up to date information and latest news.

Please also sign up to the CYSCP Newsletter and follow us on Twitter @YorkSCP