Appendix 3

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| **Safer Sleep Risk Assessment and action plan**  |
| **Expected Date of Delivery****Or** **DOB and infant’s name**  |  |
| **Parents’ names****Present Y or N** |  |
| **Date of assessment:** |  |
| **Name and title of practitioner completing assessment:** |  |
| **Risk indicators and factors identified** |  |
| **Has the baby’s sleep space been observed Y/N. If No please provide reasons why.** |  |
| **Risks identified by professional.** **Advice information and actions taken as discussed with parent.** **Is an Early Help Assessment required? Y/N****Does the risk reach the threshold for referral to social care? Y/N** |  |
| **Action plan and review date**  |  |