Serious Case Review

Child CE

Review report

Independent Reviewer: Kevin Ball

April 2020

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1. Introduction to the review

1.1. This Serious Case Review examines the involvement of agencies and professionals with a 10 week old baby, who for the purposes of this review will be known as Child CE. Child CE died in March 2019. The cause of death has been confirmed as overlay and the outcome of a Police investigation has concluded with no further action being taken.

1.2. The criteria for conducting a Serious Case Review is outlined in statutory guidance[1], namely where abuse or neglect is known or suspected and either, a child has died or the child has been seriously harmed and there is cause for concern about the way agencies have worked together. In this case, information submitted at the rapid review stage of the process about known or suspected abuse or neglect was tenuous. As the rapid review progressed further information submitted failed to strengthen a view that abuse or neglect was a contributory factor to Child CE's experiences or death. However, given the emergence of other potentially relevant information Blackpool Safeguarding Children Board determined that a proportionate Serious Case Review should be conducted.

1.3. By way of a summary, the following findings have been made;

- Based on regular interactions between the mother and relevant professionals during the pregnancy, and Child CE's first weeks of life, no concerns were observed or identified about the mother or father's care. Positive parenting was noted.
- Those professionals involved with the mother and father could have exercised greater curiosity about other adult members of the household, which in turn, may have generated a more informed understanding about Child CE's home environment.
- The outcome of the post mortem has concluded that overlay and unsafe sleeping arrangements were responsible for Child CE's death.

2. Process for conducting the review

2.1. Following the decision by the Independent Chair of the Board in April 2019 to commission this review the following steps were taken;

- Preliminary information from agencies[2] involved with the child and adults was requested in April 2019 and submitted in June 2019.
- Kevin Ball[3] was appointed as the Independent Reviewer in May 2019.
- A request to those agencies involved with the child and adults for further information was responded to in July 2019. This allowed each agency the opportunity to reflect on their involvement and to seek the contributions of those practitioners that came into contact with Child CE. As a result, agencies have been able to consider actions required of themselves in order to make improvements to practice.
- The Independent Reviewer spoke with Child CE's father over the telephone.
- Due to a delay in parallel proceedings it was not possible to conclude the review until November 2019. The final report was agreed by the Partnership in January 2020.

[1] Working together to safeguard children, 2015, HM Government under which this Serious Case Review was commissioned.

[2] The following agencies have contributed to this review:

- Blackpool Children's Social Care
- Lancashire Constabulary
- Blackpool Clinical Commissioning Group
- Blackpool Teaching Hospitals NHS Foundation Trust
- North West Ambulance Service
- National Probation Service

[3] Kevin Ball is an experienced independent consultant with significant experience of conducting case reviews.

2.2. The approach taken to conducting this review has adhered to the principles as set out in statutory guidance[4]. As such, the process has been proportionate to the case under review, and been able to capture and identify opportunities for professionals and organisations to reflect and learn lessons.

2.3. The review has considered information from May 2018 through to the death of Child CE in March 2019. Relevant historical information prior to this timeframe is included.

3. Household composition & contribution to the review

3.1. The following members of the household at the time of Child CE's death are relevant to this review.

Individual	Identified as
Subject child	Child CE
Mother	Mother
Father	Father
Half sibling 1	Half-sibling 1
Adult 1	Adult 1

3.2. Seeking the contribution of family members has been an important consideration for this review. The LSCB Business Manager and the Independent Reviewer made a number of attempts to engage the mother and father in the review. A short telephone conversation was achieved between the Independent Reviewer and Child CE's father. Child CE's father did not offer any commentary about the involvement of agencies and professionals, other than he thought that Midwives and Health Visitors were helpful. The father indicated that Child CE's mother did not wish to contribute to the review, and despite efforts to seek her involvement, it was not possible to meet or speak with her.

4. Relevant case history

4.1. In July 2018 the mother registered the pregnancy with the Midwife at a local Medical Centre at approximately 10 weeks gestation. The father was not present at this booking appointment. Routine questions were asked about domestic abuse, lifestyle and support needs, with the mother agreeing to a referral to receive support to stop smoking; she felt that no other support was needed despite low mood. GP records indicate that the mother had a short history of some pre-disposing risk factors that are known to impact on parenting capacity, these factors however do not appear to have been present as issues during the review period. The Midwife was aware of the mother's history as the mother had self-reported this information at an appointment however this was minimised and reported as being historical. The mother was assessed using the Whooley assessment questions, specifically designed for assessing depression; no concerns were raised from this assessment and the mother declined further support. The mother recounted drinking between 7 – 14 units of alcohol per week prior to the pregnancy, but reported stopping before the booking appointment. No concerns were highlighted by the GP in the referring information.

4.2. During the month prior to this booking appointment, and only now with the benefit of outcome bias, the review has ascertained that Adult 1 (Child CE's paternal uncle) moved into the household. Adult 1 has a conviction for a serious crime (not related to children) and was subject to monitoring arrangements by the National Probation Service.

4.3. Routine ante-natal appointments were attended by the mother later in July, September, October, November, December 2018, and January 2019 – no concerns were noted. Standard questioning about domestic abuse was completed with no indication that domestic abuse, or any other concerns, were an issue. During this time records indicate that two scheduled ante-natal appointments were missed by the mother; one of these was for a scan. There was also an expectation that the mother (and all mothers) would receive an ante-natal appointment with the Health Visiting Service. The mother did not benefit from this offer as she appears not to have been scheduled an appointment by the service.

[4] Working together to safeguard children, 2015, HM Government.

4.4. Child CE was born without complication and details about the birth were shared with the Health Visitor and GP as expected practice. Mother and baby were discharged from hospital to home the following day with advice and information given about safer sleeping and maternal mood. A Midwife conducted a home visit the following day and no concerns were raised. The mother did not attend a Clinic appointment three days later but did attend another Clinic the following day. Again, no concerns were noted. Home visits were completed throughout February 2019 by both Midwives and Health Visitors during which health checks were conducted along with questions being asked about the mother's health, safer sleeping, smoking, and domestic abuse. An assessment of maternal mood was also completed. No concerns or worries were noted and the Health Visiting offer remained at the Universal level.

4.5. In early March the Health Visiting Team received notification about the mother's change of address. Later in March the Health Visitor conducted a home visit noting that the mother's brother and a family friend were present. Child CE was making good progress. No concerns were noted regarding maternal mood and the mother continued to describe enjoying having a new baby to look after. No questions about domestic abuse were asked given the other people present in the household. The mother declined support for smoking cessation. An appointment was booked for Child CE's eight week check at the GP Practice and the next agreed contact with the Health Visiting programme was to be in 3 – 6 months. During this time the mother needed to register Child CE with the GP Practice.

4.6. Seven days after the Health Visiting home visit an ambulance attended the home address having been called by a male because Child CE was not breathing. The ambulance crew noted that the mother had been out and returned home to find Child CE sharing a bed with the father. Child CE was taken to hospital and sadly pronounced dead.

4.7. Throughout this time there had been no concerns about the care, safety or welfare of half-sibling 1 other than the mother expressing some worry about his speech and language development in late 2017. These worries were assessed by the Speech & Language Therapy Service as unfounded and within a normal developmental range for his age. Other than the first appointment, all other appointments for speech and language therapy for half-sibling 1 were not attended. This resulted in half-sibling 1 being discharged from the service.

5. Findings & analysis

5.1. By allowing each agency the opportunity to examine their own practice it has encouraged agencies to reflect and identify learning for themselves and identify areas for improvement. Given the very limited amount of contact the mother, father and Child CE had with agencies and professionals it follows that there is a similarly limited amount of information to review and offer any analysis. The following analysis considers the available information and offers learning points for use by all practitioners and trainers where possible.

5.2. The following areas are of interest to the review;

- The quality & effectiveness of antenatal interventions, appointments & visiting including the extent of professional curiosity.
- The quality & effectiveness of safeguarding practices by the National Probation Service in terms of identifying children with whom their supervisees live or have contact with and making notifications to partner agencies, including the extent of professional curiosity.
- The quality & effectiveness of midwifery recording following contacts with the mother/father, considering both handheld notes and electronic recording systems.
- The assessment of risk to children from all relevant members of the household.
- The response to children who are not brought to appointments.
- The extent & effectiveness of safer sleeping interventions with particular reference to drug and alcohol use by parents.

5.3. Despite there being information in the mother's background about pre-disposing risks which could be viewed as factors which might impact on the quality and effectiveness of parenting capacity, there has been no information submitted to the review which has indicated that this was an ongoing concern for professionals or the mother. Information suggests almost the opposite and that half-sibling 1 and Child CE were benefitting from good enough parenting. During the time period being reviewed the mother, father, half-sibling and Child CE were only known to universal services and contact was limited to maternity services, health visiting and primary health care services and childminding services.

5.4. The review has highlighted that these services had no concerns about the welfare of Child CE prior to birth or in the first few weeks of life. Indeed, positive progress and observations were noted and there was no information to suggest professionals needed to be concerned about Child CE's safety or welfare. No formal assessment of risk was judged necessary.

5.5. As a result of this review information has emerged that shows that there was limited curiosity by Adult 1's National Probation Services supervisor when Adult 1 moved in to live with the mother, father and half-sibling 1 in June 2018. In June 2018 curiosity and questions could have been asked about the composition of the household, whether there were children present (half-sibling 1 was at the address) and family dynamics. In February 2019, when Adult 1 shared that the new baby in the household was not sleeping, there could have been greater curiosity and questions asked about any potential safeguarding issues. Whilst Adult 1 has never been judged as posing a risk to children, was causing no concern whatsoever and has not been implicated in any way with the death of Child CE, it is evident that his previous serious crime warranted ongoing oversight. It therefore follows that this required a greater level of professional curiosity as part of the risk management arrangements than had been exercised. National Probation Service policy[5] of conducting a check on households where offenders who live in the community, in this case, did not happen. The reason for this omission is due to a misunderstanding in how this policy expectation was interpreted, but also no risks being identified and therefore a perception that checks were unnecessary. There was management oversight of this practice directing checks to be completed; this oversight, whilst positive, occurred only just prior to the critical incident and as such the actions had not been progressed.

Learning point: It is important that all professionals understand, and follow, agreed policy and procedures. Failure to do so may place a child or vulnerable adult at risk.

5.6. The Midwifery Service and Health Visiting Service have reflected on their involvement with Child CE and the mother. At the booking appointment for the pregnancy the mother reported that she had been drinking up to 14 units of alcohol per week[6] and smoking 15 cigarettes a day; she reported stopping the alcohol once she knew she was pregnant. This was an opportunity to be curious; curious about how the mother had either reduced her alcohol intake to zero in such a short timeframe or her lifestyle and habits around alcohol intake given known history. This opportunity was not taken as there was no obvious reason. Increased curiosity, or engaging in a conversation about the issues, at this moment in time might have revealed an opportunity to engage the mother in further dialogue with a possibility of early help support. The mother attended the majority of her routine ante-natal appointments and the majority of her post-natal appointments. Where appointments were missed, follow-up appointments were offered as expected. The mother's account of missing one ante-natal appointment was that she forgot. The Hospital have highlighted that there is a policy expectation that where a previous child was born small for their gestational age, additional scans are offered for new pregnancies. The mothers smoking habits would also initiate these additional scans. The fact that half-sibling 1 was born small for gestational age was picked up during this new pregnancy and

[5] Safeguarding and promoting the welfare of children, National Probation Service Policy Statement, section 4.1.4, January 2017.

[6] 14 units of alcohol per week is considered an acceptable intake according to some sources; Drinkaware & NHS alcohol units

additional scan appointments were offered. There was a missed scan appointment and mother was not re-appointed. It is not apparent from records why she was not re-appointed however health records indicate that on examination the baby was judged as growing well. As highlighted above, the need to follow policy and procedural guidance is important. In the overall scheme of an engaged and seemingly competent pregnant mother the significance of these two missed appointments is negligible.

5.7. Appropriate advice and guidance, including advice about safer sleeping, was given by the Health Visitor during post-natal appointments as well as there being good curiosity about maternal mental health, domestic abuse and support. This included the use of anxiety and depression questionnaires on two separate occasions. Review of local information and guidance for parents confirms the need for parents to avoid co-sleeping and/or bed sharing with infants when alcohol, but also drugs, are being used. This advice should be extended to all adult members of the household who may have a role in caring for a baby. Locally, there is a good offer of a perinatal educational programme for expectant parents[7] that is part of the overall Blackpool Better Start programme. Seven pre-birth and three post-birth sessions are delivered by NSPCC family engagement workers, midwives and health visitors at Children's Centres. The programme covers baby development, changes for parents, parental health and wellbeing, giving birth, caring for a baby and local services and is offered to all prospective parents in Blackpool. Neither parents engaged with this programme of support. During two of the scheduled appointments the father was in attendance (and certainly one appointment during which safer sleeping arrangements were discussed), and on one occasion half-sibling 1 was also present. Given the emergence of information about Adult 1 being in the household from just before the pregnancy was registered, it highlights an absence of information from Midwifery and Health Visiting about the members of the household. However, given that no concerns were observed or identified there was no justification to share information or take further action.

5.8. A recent multi-agency learning review conducted by Blackpool Safeguarding Children Board (MF)[8] also highlighted safer sleeping arrangements and alcohol use as an area of learning. Similar relevant findings were also noted in a Serious Case Review conducted by the Board[9] (Child BV).

Learning point: Midwives and Health Visitors are uniquely placed to identify early signs of information that might be of interest from a safeguarding perspective. Being actively curious about members of the household, family dynamics and actual, or potential, risks to children is an important consideration for practitioners. Contemporaneous record keeping is an essential requirement following all appointments and contacts.

Learning point: Fathers care for babies too. Ensuring fathers are given the same advice and support as mothers is important. When meeting expectant and new mothers, reflect on whether you are making assumptions about the role of the father in the household. It is also important to extend this advice to other significant adults who may care for a baby i.e. grandparents.

Learning point: Ensuring new parents think about safer sleeping arrangements for the baby is a core task for all professionals. Asking questions in order to encourage discussion about sleeping arrangements will help parents reflect on safer sleeping arrangements. Local information is available to support these conversations: Safer sleep for baby & How safe is your home?

5.9. The Midwifery Service has identified that record keeping was not as robust as it might have been particularly at the point of discharge, and the need to follow up missed appointments. Handheld notes taken during a home visit –

[7] Baby Steps – part of the Blackpool Better Start programme

[8] Blackpool Safeguarding Children Board: Child MF multi agency learning review

[9] Blackpool Safeguarding Children Board: Child BV Serious Case Review

on two separate occasions - were not then transferred on to the Hospital main file. These issues have already been addressed during the timeframe of the review and actions have been taken in an effort to make improvements to their systems and processes.

Learning point: Ensuring good record keeping and the central collation of records within an agency is an important and core task for all professionals. Records should be clear, accurate and completed in a timely manner. They provide a record of your work, the work you do on behalf of the agency you work for, and a record for the next worker should you decide to leave your post or be away from work. Aside from the accountability elements of recording, recording allows information to be collated and analysed should an escalation of intervention be needed.

5.10. The Health Visiting Service has identified that the mother was not offered an ante-natal appointment prior to the birth due to staff sickness and capacity which impacted on service delivery. The impact of these issues on other cases held by the service has been recognised; current data suggests improvements have been made. The benefit of this additional appointment would have been to provide further opportunities for the expectant mother to form a relationship with the Health Visitor prior to birth and discuss anything that might have been a concern. Since this time staffing capacity has increased and ante-natal contacts are now being offered.

6. Conclusion

6.1. This Serious Case Review has examined the circumstances of agency contact and involvement with a 10 week old baby who died as a result of overlay due to unsafe sleeping arrangements.

6.2. The review has confirmed that there were only a small number of universal level services involved with the mother, father and Child CE during the pregnancy and following the birth. The National Probation Service were involved with an adult male who lived in the same accommodation as Child CE and parents however there is no association with this and the circumstances of Child CE's death. Those agencies that had the greatest involvement have identified learning points which have been translated into single agency actions. The Children's Safeguarding Assurance Partnership in Blackpool will wish to scrutinise and monitor the implementation and embedding of these single agency actions.

7. Recommendations

The following recommendations are for the Safeguarding Partnership to take forward;

1. To ensure the learning from this Review is disseminated across the multi-agency safeguarding partnership to practitioners and managers.

2. To seek assurance that any identified learning by each partner agency, as a result of this Review, have been managed, implemented and embedded in a timely manner.

3. To review, Pan Lancashire, the current strategies and initiatives around safer sleeping advice, support and promotional materials and consider any changes which may promote knowledge and understanding.