Serious Case Review Executive Summary

CHILD NS

Lead Reviewer: Karen Perry

1. Introduction

1.1. This Serious Case Review (SCR) [1] is in respect of Child NS who died aged 2 months. After a night out, which involved drinking alcohol, Mother awoke in the early hours of the morning to find Child NS lifeless in bed beside her. Child NS died due to asphyxiation.

1.2. There was a range of learning from this review. The whole family, fathers and siblings as well as mothers, can be severely affected by a previous neonatal death. Parents who have experienced this are likely to be anxious about any future pregnancy. The risks of co-sleeping with babies are considerably increased when a parent is under the influence of alcohol or drugs; informing them of this verbally and via leaflets is not enough to ensure parents do not do this. Information about all members of the family should be sought from GPs during assessments and provided by GPs to child protection conferences. Any assessment of a child's needs, and the ability of parents' capacity to meet them, should consider any additional needs of siblings. This should include consulting other agencies that are involved with siblings, both during assessments and before ceasing Child in Need plans. Practitioners need to bear in mind that sometimes parents decide not to disclose key information (in this case the pregnancy) which might have a major impact on the level and nature of the support offered. Practitioners should ask open questions and probe for details about the support families are receiving.

2. Story of the child and family

2.1. Child NS lived with Mother and older siblings, some of whom had additional needs. Father lived close by and spent much of his time in the family household. Both parents were articulate and knowledgeable about their children's additional needs and involved in the care of all of them. Child NS was born prematurely. The parents had had a previous child who died after a premature birth.

2.2. In 2018, school staff made a referral to Children's Services due to changes in the presentation and behaviour of 2 Siblings, who were previously consistently well cared for. The school thought the family might need more support; a subsequent Child and Family Assessment resulted in no further action.

2.3. Also, in 2018 the eldest Sibling, who was a teenager, received an injury in the community which was serious but non-life-threatening; this was during the time when Mother was pregnant with Child NS. However, the needs of Child NS were not considered as part of the S47 enquiries, or at the child protection conference, because the parents had only disclosed the pregnancy to those services necessary to receive antenatal care. The unanimous decision of the child protection conference was for the eldest Sibling only to be made subject to a CIN plan.[2] The main component of the CIN plan

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1.1. [1] Working Together 2015 states a Serious Case Review should be held for every case where abuse or neglect is known or suspected and either a child dies or is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child. Sandwell Safeguarding Children Partnership (SCSP) agreed to undertake this review using a learning model which engages frontline staff and their managers to focus on why those involved acted as they did at the time. The lead reviewer spoke to the parents and their comments are included at relevant places in the report. The SCR took into account multi-agency involvement from the period when mother was pregnant with NS until Child NS died. The report author is Karen Perry who is an experienced social work manager who is entirely independent of the agencies involved in this case

[2] CIN plan; services provided under Section 17 Children Act 1989 to support children to achieve or maintain a reasonable standard of health or development or to prevent significant or further harm to health or development

was the involvement of the Multi-Systemic Therapy[3] (MST) team. Towards the end of 2018 practitioners considered that good progress was being made at home and at school, therefore MST involvement was to cease as a sustainability plan was in place.

2.4. Child NS was born prematurely and discharged home after a month in the neonatal unit. During this same period, there were renewed concerns about the eldest Sibling. Subsequently, as a result of a particularly difficult incident between the eldest Sibling and Mother, an MST therapist made a home visit to review the sustainability plan with Mother.

2.5. When Child NS died aged 2 months, Children's Social Care were still not aware that there was a new baby, despite the home visits of the MST therapist and social worker in the previous month. Mother had not mentioned a new baby, and neither practitioner saw any baby equipment in the home.

3. Response to neonatal death, unborn children and prematurity

3.1. Loss of a baby shortly after birth is an unexpected, traumatic and life changing event. Research shows that, although the impact is usually most severe for mothers with men feeling that their role was primarily as 'supportive partner,' fathers can also be significantly affected but tend to be overlooked by health professionals.[4] Records show that the family received support from the hospital bereavement team following the neonatal death of their previous baby. The parents told this review that they did not take up the subsequent counselling referral offered by the health visitor because they had sufficient support from their families. Father told this review that he felt included and that maternity practitioners were sensitive to his feelings too during the antenatal and postnatal period for Child NS. However, the review identified gaps in arrangements for ensuring fathers' GPs are notified about neonatal deaths and for ensuring follow up if fathers are not present on support visits to mothers.

3.2. Research indicates that children grieve just as much as adults but show it in different ways,[5] through behaviour rather than words for example. Supporting children puts additional pressure on grieving parents. The parents told this review that they did not recall being given any advice or information about the potential impact of the death on the children, or how to manage it. However, they felt the school had been caring and supportive especially to one of the Siblings.

3.3. Mother and Father told this review that they thought the antenatal care for Child NS was good physically (medically) and emotionally; practitioners knew both parents were worried about another premature birth. Neonatal unit staff offered reassurance and psychological support; the parents told this review they appreciated that the staff remembered (the death of) their previous child and felt reassured by the system of putting 'purple butterflies' in babies' records where there has been a previous neonatal death.

3.4. There was good take up of antenatal care by Mother. However, Child NS and Mother received a different (reduced) community-based service due to the premature birth; this prevented an antenatal

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[3] Multisystemic Therapy (MST) is an intensive family and community based intervention for children and young people aged 11-17, which aims to break the cycle of anti-social behaviours by keeping young people safely at home, in school, and out of trouble.

[4] Gold, K. J., Leon, I., Boggs, M. E., & Sen. A. (2016). Depression and posttraumatic stress symptoms after perinatal loss in a population-based sample. Journal of Women's Health, 25(3), 263-269. Cited in https://www.2020mom.org/pregnancy-loss-infant-death and https://www.midwiferyjournal.com/article/S0266-6138(19)30217-7/fulltext

[5] https://www.childbereavementuk.org/supporting-bereaved-children-and-young-people

visit by the health visitor from taking place and the first postnatal visit was very delayed as Mother spent much of her time at the neonatal unit. For similar reasons only one of four attempted postnatal visits by a community midwife was successful.

3.5. Practitioners told this review that there were no inherent concerns about Mother and Father meeting a premature baby's needs due to them being experienced parents who were responding well to Child NS. However, there was no evidence of any consideration of what the impact of the challenges of caring for a premature baby might have been on the siblings or vice versa. The relapse in behaviour of the eldest Sibling around the time of Child NS's birth was not known by practitioners caring for mother and baby.

3.6. The Lullaby Trust cites a number of factors associated with Sudden Infant Death Syndrome (SIDS) of which the most significant are smoking and co-sleeping especially after using alcohol or drugs.[6] Research[7] suggests that the majority of SCRs with SUDI (Sudden Unexpected Death in Infancy)[8] involved the combination of parental alcohol or drug misuse and co-sleeping, which is a frequent finding in SUDI more generally. This was true also of the sample of 40 cases of SUDI considered in the recent report from the National Child Safeguarding Practice Review Panel.[9] This report found that, as in this case, safe sleeping advice had been given to all the parents in their sample at least once, but concluded that parents do not find these interactions meaningful and had often understood the goal to be to follow the advice most of the time, rather than always.

3.7. It is not known whether co-sleeping with Child NS occurred regularly; practitioners were not aware of any occasions prior to the incident which precipitated this review. However, what is clear is that the advice given was not followed in risky circumstances by parents for whom there was otherwise ample evidence of them going to some trouble to ensure their children's needs were met.

4. How agencies worked together to support the whole family

4.1 The MST sustainability plan contained all the relevant triggers and reminders of effective previously learnt tactics should concerning behaviours re-emerge. However it could not include the impact of the pregnancy and birth, on Mother in particular, because MST staff were not aware of the pregnancy. The parents told this review that this was not a "concealed pregnancy"; given their previous experience they did not want the pregnancy widely known about until they were sure that it was viable.

4.2 The needs of unborn Child NS were not considered at the child protection conference. The social worker did not contact the GP about parents as part of the assessment; Children's Social Care managers told this review that information from GPs on parents during a S47 enquiry is not routinely sought[10] on the basis that had partners been concerned about parents they should have shared this with Children's Social Care**.** This assumes that partners are already aware of all relevant information on GP records, which was not so in this case. The GP reports on the children for the child protection

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[6] https://www.lullabytrust.org.uk/research/evidence-base/

[7] Garstang, J. J. and Sidebotham, P. (2018) 'Qualitative analysis of SCRs into unexpected infant deaths'. Archives of Disease in Childhood. doi:10.1136/archdischild-2018-315156. Available at: https://adc.bmj.com/content/104/1 (2018) and Blair, P. S., et al (2009). 'Hazardous cosleeping environments and risk factors amenable to change: case-control study of SIDS in south west England'. BMJ, 339, b3666. Cited in Brandon M etal (2020) Complexity and challenge: a triennial analysis of SCRs 2014-2017 Department of Education

[8] SUDI is a descriptive rather than diagnostic term; death of a child that was not anticipated 24 hours previously (whose cause may or may not subsequently be ascertained.

[9] Sidebotham P et al July 2020 Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm Child Safeguarding Review Panel

[10] Nor had the social worker contacted the GP after the school referral regarding siblings 2 and 3

conference did not mention Mother, so did not include that Mother was pregnant; practitioners told this review that the report forms did not explicitly ask for this information.

4.3 Each of the siblings with (different and complex) additional needs received good support from the practitioners focused on them. However, those practitioners had limited awareness of the needs of the other children in the family. There were 2 different health visitors for Child NS and another sibling; the Health Visitor for NS told this review that she did not know about the needs of the siblings until she first met Mother nearly 2 months after Child NS' birth. The school for two Siblings also told this review that they were unaware of the needs of the eldest Sibling until they attended the child protection conference. The CIN meetings for the eldest Sibling only involved practitioners involved with this Sibling. Practitioners told this review that even when professionals working with siblings were invited to CIN meetings they tended not to prioritise attendance. Ante-natal referral forms for consultant obstetric care do not refer to the needs of siblings unless there is a safeguarding concern, which did not apply in this case. Effective use of the recently created Sandwell Unborn Baby Network (SUBN) should support families where there are known parental risk factors or family vulnerabilities. However this would not have assisted in this case because criteria in the current terms of reference do not refer to the needs of other children in the family.

4.1 Whilst a number of practitioners did know that extended family members provided practical and emotional support, their enquiries about support were not successful in identifying the extent of the demands on the family in caring for them. More probing enquiries about the kind of support and from whom might have alerted practitioners to the potential for the additional challenges posed in caring for this premature baby, especially in the context of a previous neonatal death. Any parent may be reluctant to disclose gaps and pressures because, for example, pride, unrealistic expectations of family and friends, underestimating the challenges of a new baby or to avoid scrutiny by agencies - the latter of course being more worrying if there are already safeguarding concerns about the coming baby (which there weren't in this case).

4.2 The parents gave specific examples of behaviour and support that they had found helpful. This included: honest and direct but sensitive communication; compassion for their losses; making allowances for when they were upset or angry; being given information promptly; being provided with explanations of complex information; and having questions answered. They also appreciated practical support, including from the volunteers who provided activities for their children on the neonatal unit. The parents also gave examples of unhelpful behaviours. These included practitioners who "talked in riddles", did not return phone calls or cancelled appointments at short notice and made them feel judged.

5. Summary and Conclusion

6.1 Whilst there is some learning regarding the impact of a previous neonatal death on each parent and siblings both during the pregnancy and after a further premature birth, there was no significant deficit in services for Child NS. During the antenatal and post natal period appropriate advice about safe sleeping, including the increased risks associated with consuming alcohol or drugs, was given a number of times. It is not known why the parents did not follow this advice, and agencies were not aware of any occasions where they hadn't until after the death of Child NS; prior to the death practitioners had no concerns about the care of Child NS.

6.2 The triennial report mentioned previously cites research[11] which lists risk factors to be balanced with protective factors in assessing the potential for harm to an unborn baby. Risk factors include maternal physical and mental ill health, problematic use of drugs and/or alcohol, and physical violence directed at the expectant mother. Protective factors listed include good, regular ante-natal care, adequate nutrition, income support and appropriate housing, avoidance of smoking and severe stress, and social support for the expectant mother. In this case not only did practitioners believe that none of the risk factors applied, they also considered that all the protective factors were present too.

6.3 Relevant agencies generally worked well together to ensure the individual needs of the older Siblings were met; there were a number of examples of effective support and strong partnership working which included prompt and tenacious responses from a range of agencies and several examples of effective communication with both parents. However, what was missing was a through overview of all the needs of the children, the ability of the parents to meet them as a group of siblings, and the potential impact this might have when a premature baby arrived. However, whilst practitioners might have tried to offer more support had they known about all the pressures on the family, the likelihood is that the parents would have refused this, and there would have been no justification to override their consent.

6. Recommendations

To address the multi-agency learning, this Serious Case Review identified the following recommendations for Sandwell Children's Safeguarding Partnership (SCSP):

1. SCSP should consider how best to review and improve the effectiveness of current approaches to informing parents about the dangers of co-sleeping

2. SCSP should consider how best to ensure that arrangements are consistently effective to assess and promote the emotional wellbeing of all immediate family members who have experienced a still birth and/or neonatal death including siblings.

3. SCSP should consider how best to ensure that the needs of siblings are sufficiently considered collectively as well as individually especially when not all children of the family are subject to a Child in Need Plan. This should include considering how best to ensure that all practitioners are confident in exploring with parents in detail whether they need support.

4. SCSP should ask Sandwell Children's Trust to consider whether the terms of reference for the SUBN should be amended to include women where other children have significant additional needs.

5. SCSP to seek assurance from each agency involved in this review that learning points have been identified and action has been/or is being taken to address and disseminate them. This should include seeking assurance from the CCG that this is across all GP practices.

[11] Cleaver et al, (2011) Children's Needs - Parenting Capacity - Child Abuse: Parental Mental Illness, Learning Disability, Substance Misuse and Domestic Violence. London: The Stationery Office.