Derbyshire
Safeguarding Children
Board

Child Practice Review

Child C – BDS18

Lead Reviewer: Lesley Walker 15/03/19

The disclosure of any information beyond what is agreed will be considered as a breach of the subject's confidentiality and a breach of confidentiality of all the agencies involved

1. Circumstances Leading to the Review

1.1. This Child Practice Review relates to the death of Child C, who sadly died at home aged under 3 months. Child C was sleeping in bed with her mother, who got up the next morning to go downstairs. Following her return to the bedroom she recognised her baby was not breathing and called an ambulance; on attendance the ambulance crew recognised no signs of life and Child C was pronounced as life extinct at the scene. The police were immediately informed and the death was investigated in line with the SUDI Protocol (Sudden Unexplained Death in Infancy Protocol), with the on-call Consultant Paediatrician and Consultant Paediatrician fully involved; no suspicious circumstances were identified at that point.

1.2. At the time of Child C's death, the case was awaiting assessment by Children's Social Care following a referral from the Ambulance Service the previous week. This referral followed an incident where Child C was dropped from approximately 4.5 feet whilst being passed between adults during the early hours of the morning. The ambulance crew who attended and conveyed the mother and Child C to hospital raised a safeguarding referral following concerns about the incident itself, other children being present in the early hours of the morning, adults being under the influence of alcohol and ongoing arguments between the adults present at the scene.

1.3. A subsequent Post Mortem identified the cause of death as sudden infant death syndrome. (SIDS) The Pathologist stated that the incident a week before had not contributed to Child C's death.

2. Review Process

2.1. This Child Practice Review was commissioned by the Chair of Derbyshire LSCB in accordance with the learning and improvement framework for LSCBs described in Working Together to Safeguard Children guidance (HM Government 2015). The DSCB agreed that this Child Practice Review would be undertaken in accordance with Protecting Children in Wales: Guidance for Arrangements for Multi-agency Child Practice Reviews (Welsh Government 2012).

2.2. The DSCB determined that a concise Child Practice Review was the most appropriate level of review in relation to this case. This engages staff and front-line managers in reviewing cases and focuses on why those involved acted as they did at the time. Individual Management Reviews are prepared where agencies are required to consider and analyse their practice and any systemic issues.

2.3. A multi-agency Child Practice Review group was established by Derbyshire LSCB. Membership included myself as the Independent Lead Reviewing Officer and Senior Representatives from key agencies with involvement. Those Senior Representatives were responsible for preparing their agency's Individual Management Reviews. None of those involved had direct involvement in Child C's case. The members proved invaluable in probing the issues identified in the interface between agencies in this case and provided expert knowledge and insight into systems and processes in

Derbyshire. They also assisted in supporting the staff involved in the Practice Learning Event and ensured that the recommendations from this review would adequately address the learning identified and bring about the improvements identified in this case.

2.4. The DSCB set the terms of reference attached at Appendix 1 and determined that the Child Practice Review should cover the time period of 14th January 2017 – 14th January 2018. Any significant incident relevant to the case, but prior to the start of the period, was included in the analysis completed by each agency. This included information from another Local Authority, who held Case responsibility for the older half-sibling during the time period considered by the review.

2.5. As stated, a Practice Learning Event of practitioners directly involved in the case was held in January 2019, in line with the Welsh Government guidance (Child Practice Reviews; Organising and Facilitating Learning Events, December 2012), as an integral part of this review. There was good attendance and engagement by the majority of agencies involved in this case. The input of those professionals was invaluable in understanding the context and assisted in identifying the key learning and recommendations.

2.6. Family engagement was attempted in relation to this Review, although this was complicated by the timing of the review which coincided with the anniversary of Child C's death, the birth of another baby and ongoing assessments in respect of that baby. The family declined to be involved or speak to the Lead Reviewer but attempts are being made to share the outcome of the review as an absolute minimum and to keep the family aware of the publication.

2.7. Statutory Guidance expects full publication of Serious Case Review Overview Reports, unless there are particularly serious reasons why this this would not be appropriate. In working to that requirement, some case detail will not be disclosed in this report, which is written in the anticipation that it will be published.

3. Background Prior to the Scoped Period

3.1. Child C had 5 half siblings, four of whom lived within the family home. Although the oldest half-sibling did not reside in the family home, she spent significant time there. The family have had historical involvement going back over 15 years with a number of Local Authorities, prior to a relatively recent move to Derbyshire.

3.2. There is a complex family history involving historical alcohol and substance abuse.. Concerns existed about the mother's ability to adequately protect her children and interventions have included periods of Child Protection planning and Care Proceedings. This oldest half sibling was an open case at the time of Child C's death, to another Local Authority as she was the subject of a Care Order and living with close family.

3.3. As outlined, this review focussed on the 12 months prior to Child C's death, during which time there was limited contact with agencies. There were routine contacts with

Health Visiting and Midwifery Services in respect of Child C and her siblings. The mother, informed the Health Visitor that she had not taken substances or alcohol in 14 years.

3.4. The Review Team were made aware by the GP that the mother was being prescribed Codeine and Tramadol, a highly addictive and strong painkiller throughout 2016/17 following an ankle injury. It is noted that these were removed from repeat prescription by the GP when she became pregnant with Child C.

4. Key Interventions during the Review Period.

4.1. Apart from routine involvement of the agencies, the following section outlines the events that have been judged to be significant to the understanding of the work undertaken with the family during the review period. They are key from a practice perspective, rather than to the history of the child and are those thought to be most helpful in focusing the learning from this review.

School Referrals

4.2. There were three referrals from the older siblings' schools within a three month period, two of which related to concerns about school attendance of one of Child C's older half siblings who was aged 10 at this point. The key concern highlighted by the school in addition to the attendance issues, was the school's inability to get a response from the mother despite numerous attempts at contact.

4.3. The other referral related to an injury around another sibling's eye, again where the school were unable to contact the mother to discuss the issue. After a referral to Starting Point, the single point for referral to Children's Social Care in Derbyshire and contact was made by them with the mother, the mother then contacting the school. It was clarified the injury was received during a fight between the siblings.

4.4. Following contact with the mother no further action was taken in relation to these issues.

Referral in Respect of the Eldest Sibling

4.5. The mother herself appropriately contacted Children's Services Out of Hours Team for support following an threatening incident involving her eldest child, who was the subject of a Care Order.. This incident was witnessed by the other siblings and mother was pregnant at this time. Immediate action was taken by agencies, including the Local Authority responsible for the eldest child, for her to return to her agreed placement.

4.6. At this point it was identified that an Early Help Assessment was outstanding but it was appropriately agreed that a Social Care Single Assessment was necessary. The referral was categorised as a domestic abuse referral. Attempts to engage the mother proved difficult and she made it very clear that she did not want any involvement from services. An assessment was completed that concluded that no further action was required, as the eldest sibling was receiving support from the Local Authority with responsibility for her case and was not residing in the family home.

Incident involving the dropping of Child C

4.7. A referral was received from the East Midlands Ambulance Service (EMAS), following a call out to the family home in the early hours of the morning. Mother had called an ambulance after Child C was dropped 4.5 feet whilst being passed back to her by a family member. As no immediate injuries were reported a call back by a clinician was planned in line with the EMAS protocol. Two follow up phone calls to the mother were not answered and in line with the protocol an ambulance was despatched to the address.

4.8. The Crew noted that all the adults had been out at a party and were in their view intoxicated and that a baby was being passed round at that time of the morning. Other children were also present and there were arguments occurring between the adults.

4.9. Child C was conveyed to the Children's Emergency Department (CED) for further assessment and treatment, with the mother and another adult. The crew member completed an Electronic Patient Report Form (EPRF) which identified the safeguarding concerns within it and recorded that a safeguarding referral was completed. Hospital staff and the EMAS crew have a different recollection of the verbal handover in relation to these concerns.

4.10. The Hospital staff were not aware of the family background and no checks were carried out. Although it was acknowledged the mother had been drinking, she was described as "somewhat under the influence but pleasant" and staff had no concerns about her presentation. Following examination by a Doctor in ED no injuries were noted and Child C was discharged home. There was no contact with Children's Social Care by the hospital but there was a referral for follow up, by the Health Visitor in the Community.

4.11. A referral was emailed to Starting Point (Social Care) by EMAS and the information was initially screened as Child Protection and allocated to a worker for triage. This process includes sharing information with partner agencies, talking to parents and also completing a chronology of involvement from the file. On the completion of the triage, the case was re-screened by a team manager as complex needs and a Single Assessment was sent to the area for completion.

4.12. The Health Visitor reviewed the EMAS notification and planned to follow up the case with the Social Worker in 2 weeks' time and then visit the family within 4 weeks.

Death of Child C

4.13. Exactly one week later the Ambulance Service received a 999 call at 11.59am from the Mother to say that Child C was not breathing. A crew was immediately dispatched and upon arrival found a male giving CPR. On examination the crew noted that Child C was cold to touch with no signs of life and recognised Child C as life extinct. The incident was immediately notified to the police in line with the agreed protocol.

4.14. The attending crew recorded that Child C was last fed at 03:00 hours by her mother and was put to sleep in her double bed. The crew recorded that mother had got up and

gone downstairs in the morning and left Child C in bed. Child C was then checked upon the mother's return and found not to be breathing.

4.15. The Rapid Response undertaken by the Police and the Paediatrician in line with the Sudden Unexplained Death in Infancy Protocol, recorded that Child C was fed by mother at 5am and put to sleep with her in the double bed, which is where she normally slept. It also reported that mother took codeine and paracetamol due to her ankle injury and that can make her drowsy. She stated to the Paediatrician that she woke at 11am but did not check on Child C. She went downstairs to make a coffee and made a phone call and when she returned upstairs, she discovered Child C was not breathing.

4.16. The Police made extensive investigations at the property. They were made aware by the mother of the incident of the previous week and made enquiries with Children's Social Care. They were therefore aware of the fact alcohol played a role in the incident the previous week, but found no evidence of any excessive alcohol consumption. No suspicious or concerning information was found during the course of the investigation. No samples were taken from any of the adults in the house.

5. Analysis and Learning by Key Theme

5.1. From the information gained from the agency reports and from the discussions at the Case Review Group and the Learning Event the following key themes emerged. They were judged to best encapsulate the issues stemming from this review and assist in identifying the learning from this review.

Key Themes

- Professional curiosity and challenge in relation to potential injuries to pre-mobile babies where the circumstances include additional risk/ vulnerability factor (substance misuse and alcohol).
- Improved communication and clear referral pathway between the agencies at the time of the dropping incident.
- Holistic assessments involving all family members including fathers, with risks fully identified and understood.
- Unsafe sleep practice/Co-sleeping.

Professional curiosity and challenge in relation to potential injuries to pre-mobile babies where the circumstances include additional risk/ vulnerability factor (Substances and alcohol).

5.2. It was noted by the review panel that the mother had a previous history of significant substance and alcohol misuse. It is acknowledged that there was no significant evidence this continued; the mother was referred to the Specialist Midwife for alcohol and substance misuse during her pregnancy and along with her mother confirmed she was no longer using illicit drugs. However, the review panel highlighted several issues that would have benefited from more in-depth exploration. The mother reported to the Health Visitor that although she has had a history of alcohol and substance misuse, she had not used either for 14 years. The agency report highlights there should have been further exploration of this issue including the last time she used substances or

alcohol. Clearly the incident when child C was dropped involved alcohol and both the ambulance crew and the hospital staff noted that the mother was under the influence of alcohol sometime after the incident.

5.3. Furthermore, it does not appear that any of the agencies knew that mother had been prescribed Tramadol and Codeine in relation to an ongoing ankle injury, although this was discontinued approximately 12 weeks into her pregnancy. The Review Team noted that the mother did state to the Paediatrician involved, as part of the SUDI Rapid Response following Child C's death, that she had taken Codeine and Paracetamol that evening and that it could make her drowsy.

5.4. Only recently has this prescription and over the counter medication addiction been identified as an emerging and potentially significant issue for individuals, public health and safeguarding. The full extent to which it played a part in this case remains unknown.

5.5. In relation to alcohol, the police agency review also highlighted that they had been notified of an incident in 2014 where the younger children were allegedly sent to a public house late at night after a babysitter sent them there to "look for their mother".This allegation is disputed and no action was taken.

5.6. Overall, the issue in relation to the dropping of child C raised several factors about the baby's potential vulnerability, which the Review Team believe could have been more robustly investigated at the time by the various agencies. Whilst it is important to state this incident did not lead to her death, it did allow the agencies to reflect how they could improve their practice in dealing with similar situations.

5.7. As already outlined, the fact that the ambulance service believed all the adults present to be intoxicated, that all the children were out of bed and that arguments were going on whilst they were present was of significant concern and led to an email referral to Starting Point. This recognition of safeguarding concerns and the decision to refer is an example of good practice.

5.8. The information was initially screened by a social worker as meeting the Threshold for Child Protection and passed to a Pod worker for triage. This involved the worker gaining further information about the mother's presentation and speaking to the mother. The fact the mother was very concerned about any action that may be taken in light of her history, the fact that Child C had been discharged by the hospital 24 hours previously with no concerns expressed or injury noted, led to a re-screening by a Team Manager following triage and a Single Assessment recommended and sent to the local area. The risk of immediate harm appeared to be diluted and the Agency Review highlighted that the triage was too strengths based.

5.9. The Agency reports and personnel involved felt that, in light of the historical factors, the age and vulnerability of Child C, the potential for a more serious injury in light of the circumstances, issues regarding alcohol and the circumstances on the evening concerned; a strategy meeting should have been convened. Immediate sharing of pertinent information could then have occurred between the agencies, which would

have evidenced a more complex picture that by its very nature, would have merited a more robust and timelier response.

5.10. Considerable reflective work has already been completed in Children's Social Care and within Health in relation to this case and in particular the need to focus not only on the presenting information but the wider circumstances and the need for robustness in cases where there is potential for a more serious outcome. The feedback from staff during the learning event highlighted that they were clear about the need to hold a strategy meeting when dealing with cases with a complex history that involve potentially serious injuries to a pre-mobile baby. Moreover, it was identified there was a need for more timely responses in similar cases, involving potential injuries to pre-mobile babies where there is concern about potential neglect and concerning adult behaviours.

5.11. Furthermore, assumptions by other professionals about the likely action that was going to be taken and the need for robust challenge when it becomes apparent that a less urgent response is planned, were key issues highlighted by the professionals and reviewers involved.

5.12. In relation to the death of Child C it was noted that the Police were not initially aware of the incident of dropping the previous week but upon being informed and undertaking checks which highlighted that alcohol may have been a factor they took that into consideration when searching the address. There was no sign of any excessive alcohol consumption but no samples in relation to drugs or alcohol were taken from any of the adults in the house. This was challenged by the Review Team and the Police need for "reasonable suspicion" before this could be undertaken was fully explored. The Police have therefore highlighted as a recommendation "consideration for obtaining drug and alcohol samples from relevant persons should be documented with rationale." This will allow further consideration by agencies if any further action is required if parents refuse tests in such circumstances.

Key Learning

- The need for Staff to retain a high level of professional curiosity and challenge in relation to families who have a significant history, who seem reticent to engage.
- The importance of strategy meetings to facilitate information sharing and analysis in cases involving potential injuries in concerning circumstances.
- The need to keep a focus on the vulnerability of young babies when considering the urgency of action required.

Improved communication and clear referral pathway between the agencies at the time of the dropping incident.

5.13. As stated, the Ambulance Service (EMAS) picked up clearly on the presenting concerns when called out after Child C was dropped and immediately identified the need for a safeguarding referral to be made. They also transported Child C and the mother to hospital for a full assessment. There are some issues about the handover at the hospital; staff from the hospital were clear during the Practitioners Event that they were not made aware of any safeguarding concerns during the verbal handover. Equally, the EMAS staff were quoted as "pretty sure" they had stated there were

safeguarding concerns and that a referral would be completed. The electronic record does show a safeguarding concern had been raised and although this electronic record can be accessed by staff during treatment, it was not in in Child C's case. The issues raised are being addressed by Nottingham University Hospital NHS Trust.

5.14. As stated, the referral was raised through the EMAS 24/7 telephone line and was processed as a safeguarding referral. This information was shared with Children's Social Care, Child C's GP and Child Health services following an amber RAG rating being applied to it. An amber RAG rating is for safeguarding concerns that can be shared during normal working hours. The safeguarding call taker at EMAS emailed the safeguarding concern through to an unmanned emailed address, to be picked up during working hours, in this case on the Monday. The referral did not note that the mother had not responded to call backs following her initial 999 call which is why an *ambulance* was despatched and the Review Team felt it would be useful to include such information when making safeguarding referrals.

5.15. During 2018, EMAS changed their referral route for raising referrals due to service demands. The 24/7 telephone line is no longer in place and neither is the rag rating system. EMAS recognised following further information supplied during the review, that staff would benefit from a threshold style document and plan to deliver one that will support clinician decision making in relation to referrals.

Key Finding

- The need to ensure clear thresholds, protocols and pathways exist within agencies for sharing information at the point of concern.

Holistic assessments involving all family members including fathers, with risks fully identified and understood.

5.16. As highlighted earlier, a Social Care Single Assessment was undertaken when there was an allegation in relation to a violent and potentially threatening incident by the eldest sibling, whilst the mother was 17 weeks pregnant with Child C. This was considered as a domestic abuse incident which was highlighted as good practice and the impact on the family and children was considered and managed. There was good liaison with the Local Authority responsible for the eldest sibling, who was not residing at the family home. As outlined earlier, there were also contacts made in relation to non-school attendance in respect of the siblings, as a decision was made to incorporate the outstanding Early Help Assessment into the Single Assessment. At this point the mother did not want any support or involvement and was not keen to fully engage in the Single Assessment

5.17. However, the Social Care Review highlighted that "the assessment did not demonstrate any consideration for unborn Child C, or for the parental capacity to care for an additional child within the family or the potential impact a new baby might have upon the current family situation". It was felt the Single Assessment would have benefitted from discussions with other agencies and also more robust professional challenge, including contact with extended family and the new partner, father of Child

C. Overall, it was highlighted by this Case Review that little was known about the father of Child C, the precise role he played in the family and the impact of his history, including his history of offences and parenting of other children, on this family. This led practitioners to question the impact of the work completed on "Think Family" in Derbyshire and whether it was having the necessary impact on assessments and work with families throughout all the agencies.

5.18. As already stated, a more holistic assessment was due to be undertaken by Children's Social Care following the dropping incident involving Child C, but sadly she died before this occurred. As already stated, the fact that this did not take place sooner had no impact on the welfare of Child C or any of the other children, although the Review Team were clear that a timelier assessment would have been merited in this case for the reasons outlined earlier in this report.

Key Findings

- The need to ensure all assessments consider the holistic needs of the family and go beyond assessing the concerns presented at the time of referral.
- Ensuring the messages in relation to Think Family are adequately embedded in all agencies and evidenced in assessments and that there is sufficient focus on and involvement of fathers and partners.

Unsafe sleep practice /Co-sleeping

5.19. Clearly, the major theme that emerges from this case is that of co-sleeping. The Lullaby Trust record that although the figure is decreasing, 255 babies and toddlers still die every year from Sudden Infant Death Syndrome in the UK. The Research is clear and states that there is a fivefold risk of Sudden Infant Death where babies sleep in the same bed as their parents. The risk is even higher when the parents smoke, drink or take drugs. (NHS.UK)

5.20. This has led to a number of campaigns and requirements for health professional to provide advice on this issue to parents. It should be noted in this case that there are numerous good practice examples of how this message was provided and reinforced by Midwives, Health Visitors, Hospital staff and Social Care staff. At the Practitioners Event the Health Visitor was able to evidence how the mother was able to repeat the advice back to her, so it was clear it was recognised and understood. The review was clear that she regularly co-slept with her baby.

5.21. There has been significant work already undertaken by the "Keeping Babies Safe in Derby and Derbyshire Group" and the good work done to date is clearly evidenced by all the professionals involved in this case. However, it was recognised in this case that those professionals do not have a clear understanding about why the mother co-slept with her baby, which is why it would have been so valuable to have her input into this review. What was clear from the Review Team and the Practitioners Learning Event was, that in light of Child C's death, there is an opportunity to review and potentially strengthen this area of work. There were numerous excellent ideas captured during the Practitioners Event, about how this could be achieved and a willingness to reflect on the work of other Safeguarding Boards, in this area. The Police also made a commitment to join the Keeping Babies Safe in Derby and

Derbyshire Group as their officers could also have a key role to play in providing key messages to vulnerable families.

Key Finding

- The need to ensure the key messages in relation Safe Sleep are understood by vulnerable and hard to reach families.

6. Good Practice

6.1. Although some of the good practice in this case has already been highlighted in the analysis section of this report, the following key areas are important to highlight to the professionals involved:

- The referral by midwives to the Specialist Midwife for alcohol and substance misuse in light of the Mother's history
- The EMAS crew's recognition of the concerns at the home on the night Baby C was dropped and the subsequent safeguarding referral.
- The Single Assessment of the family's circumstances in relation to the concerns expressed about the eldest sibling.
- The Hospital referral to the Health Visitor in relation to the admission of a pre-mobile baby.
- The advice given to the Mother in relation to Safe Sleep from numerous professionals involved.

7. Conclusions and Recommendations

7.1. The Review concluded that the death of Baby C from SIDS was neither predictable nor preventable. There was in fact significant evidence of good practice in this case but equally learning, that although having no impact on this case overall, could improve practice in relation to future cases where there is a potential or actual injury to a pre-mobile baby.

7.2. The key themes and findings were explored by the Review Team and during the Practice Learning Event; it was recognised that some of the key issues highlighted, are already receiving considerable attention and action, following the learning from this case and others. In particular, there are a number of development activities taking place within Derbyshire around the quality of assessments including assessments during triage within Starting Point. This work includes reviewing and strengthening professional curiosity and awareness of disguised compliance and the importance of holistic assessments. There was also evidence of additional training across agencies in relation to Think Family and highlighting the importance of engaging fathers.

7.3. Moreover, work has occurred and is ongoing with Children's Social Care Team Managers and Social Workers regarding screening and decision making, specifically taking into consideration the role of strategy discussions. This has included the updating of guidance (Updated Practice Matters 24/04/18). This work, alongside such improvements as monthly multi-agency reflective supervisions in

Starting Point and better used of Safeguarding Advisers; are clearly seeking to improve and promote healthy challenge.

7.4. In light of this, it would not be appropriate to make further recommendations to address these areas. However, the Safeguarding Board may wish to seek assurance in relation to the impact of this work on practice.

7.5. The Review team also considered the best way to reinforce the message about the need to keep a focus on the vulnerability of young babies when considering the urgency of action required. Discussions in relation to emphasising the vulnerabilities of babies in training and via other forums, whilst helpful were not felt to sufficiently pick up on the factors that influenced why the focus on this obvious vulnerability was not maintained. In light of the pro-active approach in Derbyshire in relation to the vulnerabilities of babies and young children, the Review Panel consider that a special event or promotion of this issue, using the learning from this case along others may be the best way to achieve this.

Recommendations

1. The DSCB should consider how to best highlight the vulnerabilities of babies and the need for a timely response and robust assessment in all concerning cases.

2. The DSCB should support the Keeping Babies Safe in Derby and Derbyshire Group, to review the current approach in Derby and Derbyshire with a view to improving and enhancing the work.

Appendix 1 – Terms of Reference

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and the LSCB, both throughout the scoping period and with specific reference to responses to the incident on 07/01/18.
- Examine inter-agency working and service provision, including quality of assessments, for the child and family.
- Examine the effectiveness of information sharing/ working relationships between agencies and within agencies;
- Determine the extent to which decisions and actions were child focussed on AH;
- Determine the extent to which the lived experience of the children in the family was understood by agencies and informed the support offered.
- Examine the effectiveness of information sharing/ working relationships across borders;
- Examine how well the role of the eldest sibling was understood and any impact on the family;
- Explore whether the impact of the pregnancy with AH was fully explored and informed the support offered.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects and progress.
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard children;
- Identify any actions required by the LSCB to promote learning to support and improve systems and practice.