Suffolk Safeguarding Children Board

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Kevin
Harrington
Associates
Limited

BABY D

A SERIOUS CASE REVIEW

Kevin Harrington JP, BA, MSc, CQSW

CONTENTS

1. INTRODUCTION

1.1 This report concerns a baby, referred to in the report as Baby D, who died at the age of 12 weeks. He had slept in the same bed as his mother who awoke to find that he had died during the night.

1.2 These matters were brought to the attention of the Suffolk Local Safeguarding Children Board (SLSCB). The Chair of that Board, Ms Sue Hadley, decided that the circumstances of the child's death required that a Serious Case Review (SCR) should be conducted, in line with the government's guidance[1].
This is the Overview Report from that SCR.

1.3 An SCR must be carried out when a child dies and there are concerns that the child may have been abused or neglected. In this case those concerns related only to the issue of whether the sleeping arrangements for the child had been safe and satisfactory on the night of his death. There had been no previous concerns about the care of Baby D, and none emerge from this review.

2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

2.1 This SCR was formally initiated by Ms Hadley on 24th August 2015. The SLSCB appointed an experienced independent person – Mr Kevin Harrington[2] - to act as Lead Reviewer and to write this report. Mr Harrington has been assisted by the officers of the SLSCB and a reference group of senior representatives from the agencies which had been involved with the family of Baby D.

2.2 All those agencies were required to submit a chronology and a report containing an analysis of their involvement. Those agencies are detailed in the table below, and are subsequently referred to by the acronyms / abbreviated forms provided.

AGENCY	NATURE OF INVOLVEMENT
Suffolk Constabulary	Investigated the circumstances of the death to determine whether any crime had been committed
Suffolk County Council, Children and Young People's Services (CYPS)	No significant involvement in respect of Baby D
Suffolk County Council Health Visiting services	Provided a full health visiting service following the birth of Baby D
Suffolk County Council School Nursing service	No involvement in respect of Baby D
The General Practitioner	Provided GP services to the family throughout the period under review

[1] "Working Together to Safeguard Children" (2015), referred to in this report as Working Together
[2] Appendix A of this report contains brief autobiographical details,

Health overview report – Ipswich and East Suffolk Clinical Commissioning Group (CCG) and West Suffolk CCG	This agency has provided an overview of all NHS services provided to the family
East of England Ambulance Services	Involved only in conveying Baby D to hospital following his death
West Suffolk Hospital NHS Trust	Maternity services

2.3 The Terms of Reference for the review, adapted so as to be suitable for publication, are at Appendix B. They are drawn from Working Together 2015, amended to reflect issues specific to the circumstances of this case.

2.4 The agencies were asked to review their involvement with the family during the two years before the death of Baby D. This was because some agencies had been significantly involved during that time with an older half-sibling, a child of the mother, Ms M, from a previous relationship. This child is referred to in this report as Child P.

2.5 The Terms of Reference for the review state that

"The timeline of involvement with the sibling, pre-dating the birth of the subject, will be an important reference for the review."

It is important when conducting reviews such as this that the events leading to the review are seen in the context of the contributing agencies' overall involvement with the family. However, it is also right to emphasise that this is not a review of the agencies' involvement with Child P. That involvement did not arise from safeguarding concerns. There is nothing in the agencies' contact with the family in respect of Child P which would lead to a Serious Case Review being carried out. On the conclusion of this review the content of this report which does refer to Child P was shared with his father.

3. METHODOLOGY USED TO DRAW UP THIS REPORT

3.1 This report is based principally on the Management Reviews and background information submitted by the agencies, subsequent Panel discussions and dialogue with the agencies and the family.

3.2 This report consists of

- A factual context and brief narrative chronology.
- Commentary on the family situation and their input to the SCR.
- Analysis of the part played by each agency, and of their submissions to the review.
- Identification and analysis of key issues arising from the review.
- Conclusions and recommendations.

3.3 The conduct of the review has not been determined by any particular theoretical model but it has been carried out in accordance with the underlying principles of the statutory guidance, set out in Working Together. The review

- *"recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight[3];*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings".*

3.4 The government has introduced arrangements for the publication of Overview Reports from Serious Case Reviews, unless there are particular reasons why this would not be appropriate. This report has been written in the anticipation that it will be published, and it is suitable for publication.

4. FAMILY BACKGROUND

4.1 Baby D's family are white British and have lived in Suffolk for many years. Baby D lived with his mother, his father Mr F, and his half-brother. Previously Ms M had been married to Mr G, the father of Child P.

5. THE INVOLVEMENT OF THE AGENCIES CONTRIBUTING TO THIS REVIEW

5.1 Child P started school in 2013, by which time the parental relationship was in difficulties: Ms M and Mr G were to divorce later that year and there is evidence that their separation was acrimonious.

5.2 Child P's behaviour at school gave cause for concern from an early stage, although the head teacher has reported that there was no history of this at pre-school. Ms M consulted the family GP about this, reporting a range of behavioural difficulties. From then on, throughout the period under review, there was mounting evidence of cause for concern about the behaviour of Child P, which became extremely challenging, and his family's ability to manage this.

5.3 A range of agencies worked intensively with the family to try to tackle this. The relationship between the birth parents remained strained but both of them, and other family members, tried to co-operate and work with the agencies. However there is little evidence of any enduring improvement in the situation, which will have been very stressful for the family. Those pressures will have been compounded at times by housing problems – they moved house not long before Baby D was born - and some financial difficulties.

[3] This review does not rely on hindsight, and tries not to use hindsight in a way that is unfair. It does use hindsight where that promotes a fuller understanding of the events and their causation.

5.4 In July 2014 Ms M's pregnancy with Baby D was confirmed. At her first contact with ante-natal services it was recorded that Ms M said that she had previously used cannabis and alcohol. (When interviewed for this review she said that she had never used cannabis and made no such comment). She went on to make full and appropriate use of maternity services throughout the pregnancy. She proactively contacted midwives to talk about the stress she was experiencing as a result of the difficulties with Child P, and was also assisted with this during the pregnancy by her GPs.

5.5 Ms M had some ill health during the pregnancy and spent some days in hospital on two occasions. Baby D was then born prematurely, at nearly 36 weeks' gestation, following a difficult labour. There were some post-natal complications requiring treatment on a neonatal ward but in due course Baby D was routinely discharged from midwifery care.

5.6 The Health Visitor's New Birth Visit was carried out when Baby D was two weeks old. The Health Visitor recorded that there was good attachment between baby and mother and that the home conditions were good. At a follow up visit a week later the Health Visitor again noted good attachment and that the baby was content and feeding well.

5.7 During these weeks after the birth of Baby D agencies noted some improvement in Child P's behaviour and decided to decrease some of their intensive interventions with the family, although investigations to explore the underlying causes for Child P's problems continued. There is evidence of liaison between school nursing staff, dealing with Child P, and the Health Visitor about this. However the improvements noted were very short-lived and, after a week, agencies decided that the previous level and nature of their input should be restored.

5.8 Around this time the Health Visitor saw the family at home for the third time, when Baby D was about six weeks old. The Health Visitor again noted good attachment between baby and mother and good home conditions. The baby had gained weight, although parents reported some feeding difficulties and the Health Visitor gave advice appropriately, planning to review the situation in two weeks' time.

5.9 The family took Baby D to the GP for the routine 4-8 week post-natal check, and the GP described him as alert, attentive and gaining weight appropriately. His mother spoke again about feeding problems and the GP agreed that this would be monitored.

5.10 The agencies working with the family in respect of Child P were concerned about the stress Ms M was experiencing and her low mood, and shared information about this. The Health Visitor again visited the family and spoke with Ms M about her worries, all of which related to Child P rather than the baby. The Health Visitor made an appointment for Ms M to see her GP although she did not in fact see the GP on this occasion, because of a misunderstanding as to which GP she was registered with.

5.11 The Health Visitor called to the home again the following day, on this occasion to carry out their routine “six week visit”. The situation with Baby D remained the same, with age appropriate development observed, good attachment from both parents who were seen to handle the baby confidently and gently, while the home remained clean and tidy.

5.12 However the agencies dealing with the family in respect of Child P were becoming increasingly concerned about that situation. Despite intensive, co-ordinated input Child P’s behaviour was causing mounting concern, as was Ms M’s ability to cope with this. There was an additional concern in that Mr F was now working away from home during the week, so that the pressures on Ms M became greater. One of the lead professionals working with the family discussed the situation with the Health Visitor and they agreed to visit together.

5.13 Before they were able to do so agencies were alerted to a situation in which Ms M’s whereabouts could not be traced for several hours. Family members cared for the children until Ms M made contact, reporting that she had become overwhelmed by the situation and needed time alone. Ms M spoke to various professionals and agreed that a referral should now be made to the local authority’s Children and Young People’s Services (CYPS).

5.14 The referral was made by the school which Child P attended and arrangements were made for a social work assessment. That assessment was arranged jointly with the lead professional who was already involved with the family and went ahead without delay. Ms M told these professionals that she did not think she could continue to care for Child P. This led to discussions with Child P’s father and an agreement that with immediate effect Child P would move to live with him.

5.15 Sadly, Baby D died the following day. Ms M had brought the baby to sleep with her and woke to find that he had died during the night. Emergency services were called and he was taken to hospital but it was confirmed that he had been dead for some time. A police investigation was commenced in line with standard arrangements in such circumstances.

5.16 It emerged that Baby D’s parents and some friends had been drinking at a local public house the evening before the death. It was later said that they and friends then returned to the family home where more alcohol was consumed, and it was alleged that some of those present were using illegal drugs. In that context, although there was no suggestion that there was any maltreatment of Baby D, the decision was taken that this SCR be carried out.

6. THE FAMILY

6.1 Baby D's mother and father were visited twice by the Safeguarding Board Manager in connection with this review. At the first visit, in October 2015, they were formally advised that this SCR was being carried out and why that was necessary. The purpose of the second visit in February 2016 (when the Lead Reviewer was unable to attend) was to explain the outcomes of the review and to go through this report with them. On both occasions their distress, and particularly that of Ms M, was very evident.

6.2 They told the Board Manager that overall they felt this report appropriately reflected the events leading up to the death of Baby D. However Ms M expressed her concerns regarding the recording made by the midwife at the early stage of her pregnancy, that she had previously used alcohol and cannabis. Ms M wishes it to be known that she had never used cannabis and stated that toxicology tests following her child's death showed no evidence of the drug.

6.3 The parents said that they had not received any information about safe sleep or co-sleeping from any of the health professionals with whom they had contact. Ms M also said that while in hospital following the birth of Baby D she had the baby in bed with her, day and night. She reported that, although she was warned that the baby might fall out of bed, nothing was said about the dangers of co-sleeping.

6.4 This is not consistent with the reports to this review from the hospital and other agencies. It is not the policy of West Suffolk NHS Foundation Trust to advocate or facilitate co-sleeping. The agencies' accounts, including the extent to which contemporaneous records were made, are described elsewhere in this report. The conflicts between these accounts will not now be resolved but, in any event, it is clear that the key lessons to be learned from this review do relate to safe sleeping.

6.5 The parents also reported some dissatisfaction with the nature and quality of their contact with some of the maternity services provided. The detail of those comments, which do not relate to safeguarding, has been fed back to the relevant agencies.

7. THE AGENCIES

7.1 Introduction

7.1.1 This section of this report considers the involvement of each of the agencies contributing to this review, in the order that they appear in the chronology, highlighting any key lessons learned.

7.1.2 "Safe sleeping", the only significant cross-cutting issue to arise from this review, is considered separately below.

7.2 The General Practitioner

7.2.1 The GP was appropriately and fully involved with the family throughout the period under review. Ms M chose to stay with this GP even after moving some distance away because she valued the quality of care provided. The Management Review summarises this:

"The primary care offered to both children and Ms M in her care for them was of an excellent standard and does not give rise to any "lessons learned".

7.3 West Suffolk Hospital NHS Foundation Trust.

7.3.1 This hospital provided maternity care for Ms M and her baby. Ms M was entirely co-operative with maternity services and there are no issues arising, relevant to this review, in respect of the clinical care provided during the pregnancy and thereafter, although, as described above, the family have now expressed some dissatisfaction with aspects of the service provided.

7.3.2 The hospital has identified some weaknesses in record keeping. Staff had not fully complied with requirements accurately to document routine enquiries about domestic abuse and misuse of alcohol. Staff will be reminded of these requirements although there is no indication of any domestic abuse during the review period, and no firm evidence that misuse of alcohol affected the care of Baby D.

7.4 Suffolk County Council: Health Visiting and School Nursing Services

7.4.1 The report from this agency is particularly significant in the sense that the Health Visitor was the professional who had most contact with the family directly in respect of Baby D.

7.4.2 The report notes some issues relating to record-keeping but otherwise there is clear evidence that the Health Visitor's input was timely, proactive and in line with good professional practice standards. The Health Visitor was also alert to the issues relating to the older child, liaised appropriately with the relevant services and recognised the potential implications for Baby D. The Management Review reflects that

"Baby D's health records indicate no concern for his health, development, care and attachment with his parents…Attachment had been considered at all contacts between him and his parents, and lots of positive interaction recorded including confident and gentle handling. He lived in a clean tidy home with loving parents and the health visitor had never seen any evidence of substance use (alcohol or drugs)".

7.4.3 School nursing services were involved only in respect of Child P.

7.5 East of England Ambulance Service NHS Trust

7.5.1 This service was involved only in attending the home and conveying Baby D to hospital where his death was confirmed. The report from this service notes that the call they received was allocated the highest priority, but that they were unable to attend within the target time of 8 minutes. Instead it took 11 minutes for the ambulance to arrive. This is attributed to the remote location and the distance the ambulance had to travel. On arrival the crew immediately identified that Baby D had already died and it was futile to attempt resuscitation. No learning points arise for the service from their limited involvement in this case.

7.6 Suffolk Constabulary

7.6.1 Police had no significant involvement with any family member prior to the death of Baby D.

7.6.2 Police and ambulance services were called to the family home by Mr F following the discovery that Baby D had died. A police investigation commenced. The parents gave an account of going to a local public house and returning in the early evening before settling down for the night. Ms M fell asleep with Baby D in her arms and awoke to find that he had died. There was no indication of any injury to the child. Police inspected the home and found it clean and tidy. Nothing about the parents' presentation or demeanour gave any cause for concern.

7.6.3 Police concluded that the death was unexplained; that there were no suspicious circumstances and it was a tragic accident. The matter was to be referred to HM Coroner and a subsequent post mortem gave the cause of death as Sudden Unexplained Death in Infancy or Childhood (SUDIC).

7.6.4 Some days later police received anonymous information to the effect that they had been given an inaccurate/incomplete account of the events prior to the death. It was alleged that a number of people had been involved in the events at the public house and the family home on the evening before the death, and that illegal drugs had been taken. It was further said that, when the body was found, attempts had been made to conceal the events of the previous evening and to tidy up the home before emergency services were called.

7.6.5 This raised the possibility that an offence may have been committed. Police carried out new investigations which to a limited extent confirmed the anonymous report received. A number of people had been at the home, there was some noise nuisance and some of those present were drinking heavily. Both parents were arrested in the course of these enquiries. However police concluded that there was insufficient evidence to meet the "Full Code Test[4]" and no further action was taken in relation to any prosecution.

7.6.6 Police have identified key issues which they took into account. The parents' evidence had not been entirely consistent and there were allegations that Ms M

[4] The "Full Code Test" sets out the principles to be followed by police and prosecutors in making decisions on whether or not to charge a suspect.

was drunk, although equally there was evidence that she consumed little or no alcohol. She has been absolutely clear that she was not drunk, and in fact did not drink at all as she was driving.

7.6.7 There was no independent or toxicology evidence to support the allegations made, while ambulance and hospital staff did not have any concerns about the parents' presentation. Most importantly, the pathologists' findings were inconclusive and there was evidence that, prior to these events, the care of Baby D had been of a high quality.

7.6.8 In their report to this SCR police confirm that their management of this situation was necessary and appropriate. The situation was dealt with in line with the Constabulary's policy and procedures and no new learning points arise from this review of their involvement.

7.7 Suffolk County Council, Children's Social Care Services

7.7.1 The local authority's CSC service has provided a full review of their work but this relates almost entirely to the "Early Help" services provided in respect of Child P. There are no matters arising from the brief involvement of social workers just before the death of Baby D.

7.8 Ipswich and East Suffolk CCG and West Suffolk CCG: Health Overview Report

7.8.1 The Designated Nurse for Child Protection from the Ipswich and East Suffolk CCG and West Suffolk CCG has submitted a report which takes an overview of the work of the NHS agencies involved. The key issues from that report are reflected above in respect of each agency.

8. KEY THEMES

8.1 Safe Sleeping for Babies

8.1.1 This SCR is unusual in that in almost every respect the care of Baby D was exemplary and he was a much loved, healthy child. The issue which has led to this SCR is the sleeping arrangements on the night that he died.

8.1.2 On that night Baby D and his mother slept together in the same bed – often referred to as "co-sleeping". This is not an unusual practice. The National Childbirth Trust (NCT) has suggested that perhaps half of the mothers in the UK co-sleep with their baby at some time.

8.1.3 However it is clearly evidenced[5] that there is an association between co-sleeping and Sudden Infant Death Syndrome (SIDS). Consequently the

[5] See, for example, Mitchell, E., 2010. Bed sharing and the risk of sudden infant death: parents need clear information. Current Paediatric Reviews, 6(1), pp.63-66.

Department of Health has advised that co-sleeping is inadvisable when one or both parents:

- Is a smoker.
- Has consumed alcohol.
- Has taken any drugs, prescription or otherwise, that might cause drowsiness or affect how deeply you sleep.
- May be extremely tired.

8.1.4 The risks of co-sleeping are also increased where a baby:

- was born prematurely (37 weeks or less).
- had a low birth weight (less than 2.5kg or 5.5lb).
- has a fever or any signs of illness.

8.1.5 It can be seen that there are some correspondences between these risk factors and the circumstances in which Baby D died. This is not to say that the death was a consequence of one or more of the associated issues, but the association should be recognised, and forms the basis for the decision to conduct this SCR.

8.1.6 As a result of the growing recognition of the risk factors associated with SIDS, all relevant agencies have increased the extent to which they require staff to talk to families about safe sleeping. Each of the NHS agencies involved in this SCR has considered this and reported back as follows:

- Neither the GP nor the midwife gave any safe sleeping advice to the family, assuming that the Health Visitor would do so.
- The Health Visitor did not give safe sleeping advice ante-natally – there was no ante-natal contact with the Health Visitor because of confusion about the family's address.
- The Neonatal Unit gave detailed advice about safe sleeping, including co-sleeping, both verbally and in writing, and this is documented.
  It is not the policy of West Suffolk NHS Foundation Trust to advocate or facilitate co-sleeping.
- The Health Visitor gave detailed advice about safe sleeping on two post-natal visits, but did not make a note of having done so on the child's records.

So, some advice was given appropriately but there is room for improvement for the agencies to meet the standards they set themselves, and in the overall co-ordination of how advice is given.

8.1.7 The SLSCB has also provided the following account of the work carried out to improve public awareness and staff awareness, of the issue of "safe sleep".

"*The SLSCB held a Safe Sleep Launch in 2014 in partnership with the Lullaby Trust. 65 delegates attended. Safe Sleep guidelines were produced. The guidelines' purpose is to support practitioners to give appropriate information*

In December 2014, The National Institute of Health & Care Excellence (NICE) recommended all healthcare professionals and families be fully informed of the association between co-sleeping and SIDS.

and advice to parents/carers to enable them to make an informed choice about safer sleeping arrangements for their babies. Leaflets, posters and links to Safe Sleep Advice are on the SLSCB website. Safe sleep leaflets were promoted with midwives and health visitors in particular and information packs sent out to children's centres.

http://suffolkscb.org.uk/information-and-links/safer-sleep/

A professional's newsletter went out from the LSCB in December 2014 giving safe sleep information to professionals. Information for teachers was included as part of the PSHE framework for parenting sessions.

A further initiative was run by Public Health[6] in 2015. The Health and Wellbeing Board website 'Health and Wellbeing Suffolk' have a Safer Sleeping Suffolk web page with a range of videos, leaflets posters etc. A printable safer sleeping guide was produced and there is a short video that includes key information regarding drinking, smoking, co-sleeping etc.

There was media coverage at the time and circulation to professionals to ensure that safe sleep messages were delivered to all new parents. Midwives and health visitors both ask about safe sleeping arrangements and give out leaflets.

http://www.healthysuffolk.org.uk/projects/safer-sleeping/

Further Safe Sleep events will be run in Spring 2016".

[6] The Public Health service, managed within the local authority, is the lead agency for promoting safe sleeping in Suffolk

9. RECOMMENDATIONS

9.1 In the unusual circumstances of this SCR, the principal recommendations relate to the role of the SLSCB in

a) improving professional practice in relation to safe sleeping and

b) contributing to arrangements which promote public awareness of the importance of safe sleeping.

Recommendation 1

The SLSCB should explore, in consultation with the Child Death Overview Panel (CDOP)[7], the Clinical Commissioning Groups and Public Health services, the introduction of consistent safe sleep assessment and recording arrangements, to be undertaken by health professionals for all new babies in Suffolk.

Recommendation 2

The SLSCB should continue to work with Public Health services and other partner bodies to promote public alertness to the importance of safe sleeping for infants.

Recommendation 3

The SLSCB should carry out regular audits to evaluate the extent to which

a) safe sleeping advice is being given to families by professionals and

b) professionals are keeping full records of having done this.

Recommendation 4

Any incidental learning identified as part of the analysis and chronology will be captured in a single agency action plan which will be monitored by the SLSCB.

[7] CDOPs are responsible for drawing together and considering all child deaths in a locality, including deaths which may raise safeguarding concerns. This is in line with Chapter 5, Working Together 2015.

APPENDIX A: THE LEAD REVIEWER

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on some 50 Serious Case Reviews in respect of children and vulnerable adults. He has a particular interest in the requirement to write SCRs for publication and has been engaged by the Department for Education to re-draft high profile Serious Case Review reports so that they can be more effectively published.

Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He has served as a magistrate in the criminal courts in East London for 15 years.

APPENDIX B: TERMS OF REFERENCE

These are the Terms of Reference for this SCR, modified so that they are suitable for publication.

1. Introduction

A decision was made by SLSCB's Independent Chair to undertake a Serious Case Review in respect of Baby D, who tragically died in sudden and unexpected circumstances. It was decided, on the basis of the consultation and discussion with the relevant parties, that this case met the criteria for a Serious Case Review (SCR) as laid out in statutory guidance issued by HM Government in Working Together to Safeguard Children 2015[8].

2. Aims of the Review

To review the circumstances leading to Baby D's death in order to establish what lessons, if any, are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.

To identify clearly what those lessons are, both within and between agencies; how and within what timescales they must be acted on and what is expected to change.

To involve the family of Baby D as considered appropriate and in accordance with their wishes and feelings.

To complete an independent SCR Report for presentation to the SLSCB within 6 months of commencing the review and assist in the preparation of the report for publication.

The final SCR Report will:

- Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- Be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- Be suitable for publication without needing to be amended or redacted.

3. Scoping Period for the Review

The review will consider agency involvement with family members in the two years before the death of Baby D. The timeline of agency involvement with a half-sibling, pre-dating the birth of the subject, will provide an important context for the review.
Agencies will be requested to review records held in relation to the family and provide additional details of any significant information or involvement with the family outside of the prescribed timescale at their discretion.

[8] Working Together 2015, HM Government

4. Governance Arrangements

The SLSCB Case Review Panel will be responsible for all commissioning arrangements and will monitor progress of the review to ensure it meets the requirements of Working Together 2015. The independent Overview Report Writer will be entirely independent of SLSCB. They will develop the learning recommendations and write the SCR Overview Report.

An officer from each agency involved with the case will be tasked with the completion of a chronology detailing the involvement of their service, along with a thorough analysis of the quality of the service offered. The chronology and analysis will follow a prescribed format agreed by the Overview Report Writer.

A Reference Group of senior managers will be responsible for assisting the Independent Overview Report Writer in providing a local strategic overview, organisational context and challenge as the analysis of professional practice and learning develops.

Members of the Reference Group will provide support to the analysis and chronology writers throughout the review process and will ensure that reports and any subsequent requests for information from the Overview Report Writer are provided within the agreed timescales of the review.

5. Methodology

The emphasis of this review will be on the involvement of 'primary' level services i.e. universal health services and early intervention/non-statutory children's services.

All agencies should produce a robust, comprehensive and accurate chronology of their engagement with the child and family. The chronology should also detail contacts with other key agencies working with the family, demonstrating the effectiveness of joint working and information sharing between services and each chronology should be accompanied by an open, thorough and critical detailed analysis of the information gathered. The analysis should consider whether there were any areas of culture, language or disadvantage and/or social exclusion for the family and its potential impact on the outcome for the child, any relevant statutory requirements and/or procedures and any learning already identified.

In the event that there is a parallel continuing criminal investigation, the police representative member of the SCR Reference Group will work closely with the SLSCB and Senior Investigating Officer to ensure that any interviews and/or information sharing takes place appropriately so as to minimise the opportunity for conflict between the SCR process and criminal investigations/CPS activity. This would be informed by current ACPO/CPS Guidance[9] around such parallel processes.

[9] Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews 2014, ACPO & CPS

6. Involvement of Family Members

SLSCB recognises the value that the involvement of family members can have in the SCR process and will ensure their expectations are managed appropriately and sensitively.

As part of this review process the Overview Report Writer or a person nominated by the Overview Report Writer will seek to engage with family members so that their views can be taken into account within the discussions and analysis of professional practice.

7. Reflection and Review of the Multi Agency Sudden Unexplained Death in Childhood (SUDIC) Investigation Process

SLSCB is carrying out a parallel piece of work, undertaken outside the scope of this SCR, which considers how agencies work together after the sudden unexplained death of a young child. The learning from that exercise will be drawn together with the SLSCB response to this SCR report.

8. Liaison with outside bodies, including the Department for Education and National Panel of SCR Independent Experts

Until completion of the SCR Independent Report and consideration of its content by the SLSCB, no information arising from it or in connection with it should be shared with any organisation outside of the review process without the express authority of the SLSCB Independent Chair or in their absence the Vice Chair.