Suffolk Safeguarding Children Board

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LSCB SCR Response – Baby 'D'

Introduction

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.

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 as laid out in HM Government *Working Together to Safeguard Children 2015*.

A 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.

This SCR was formally initiated by Ms Hadley on 24th August 2015. Suffolk LSCB appointed an experienced independent person, Mr Kevin Harrington, to act as Lead Reviewer and to write this report. 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.

In writing the report Kevin Harrington was assisted by the officers of Suffolk LSCB and a reference group of senior representatives from the agencies which had been involved with the family of Baby D.

The 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

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 2015. 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[1];*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings".*

The agencies were asked to review their involvement with the family during the two years before the death of Baby D. This was due to some agencies having had significant involvement 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. However it is also right to emphasise that this is not a review of the agencies' involvement with Child P and 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.

Apart from the circumstances leading to his death, the agencies found no cause for concern. Baby D was healthy and was well loved and well cared for throughout his life. However he died after sleeping in the same bed as his mother – co-sleeping. This practice is known to be associated with Sudden Infant Death Syndrome (SIDS). Issues related to SIDS lead to the principal recommendations from the review, set out below.

The LSCB held an extraordinary Board meeting on the 7th March 2016 to consider the Serious Case Review report. It fully accepted the lessons learned and recommendations outlined in paragraph 9 of the report. It then went on to consider the actions already taken to date as a result of the learning, their impact, and any further actions required to address the learning.

[1]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.

Recommendations

In the unusual circumstances of this SCR, the principal recommendations relate to the role of the LSCB 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 One:

Suffolk LSCB should explore, in consultation with the Child Death Overview Panel (CDOP), 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.

Public Health is in discussion with CCGs to agree specific KPIs to maximise and monitor implementation of Safer Sleeping Suffolk Strategy and its 6 messages and provision of a thermometer for all mothers and their new babies.

The LSCB Health sub-group, in conjunction with the Chair of the CDOP, will lead on the consultation and exploration of consistent assessment and recording arrangements and report back on the progress made to the LSCB via sub-group reporting at regular intervals.

Recommendation Two:

The SLSCB should work with partner bodies to promote public alertness to the importance of safe sleeping for infants.

Suffolk LSCB first launched a campaign to promote public awareness to the importance of Safe Sleep in 2014 in partnership with the Lullaby Trust. As part of that campaign, guidelines were developed and information shared with all partner agencies, including information for Teachers to support PSHE framework for parenting sessions. Safe sleep leaflets were promoted with midwives and health visitors in particular and information packs sent out to children's centres.

A further initiative was run by Public Health, in conjunction with the LSCB, 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 and to encourage midwives and health visitors to both ask about safe sleeping arrangements and give out leaflets.

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

In response to this Review, and as part of an ongoing awareness raising campaign by the LSCB and Public Health, two safe sleeping events are taking place in March and April 2016. They are free and open to anyone working with children and their families. The first event attracted in excess of 50 professionals from across the LSCB partnership.

The programme includes:

- Suffolk Safer Sleeping Strategy – Implementation update
- Evidence update/Data/Risk Factors
- SUDIC process – A police perspective
- Lullaby Trust presentation
- Safer Sleeping Suffolk Evaluation – survey results
- Table Top Discussions as to how to spread the Safe Sleep message.

A Safe Sleep newsletter and information for schools will be sent to all LSCB partners, including Children's Centres and Schools.

Recommendation Three:

The LSCB 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.

The LSCB Learning and Improvement Group will ensure that all agencies who have a responsibility to give Safe Sleep advice as part of ante-natal and post-natal care undertake regular auditing and report to the L&I Group.

Implementation of a consistent message as outlined in Recommendation One will lead to the potential for an over-arching audit to assess the effectiveness of safe sleep messages across the Health partnerships***.***

Recommendation Four:

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 LSCB.

Action plans and first progress reports to come to the Local Safeguarding Board meeting on 26th April 2016 for approval.

The action plan will be monitored by the LSCB Learning and Improvement Group with exception report to each Board meeting.