Child I Serious Case Review: Overview Report

Version 8

PSCP
Portsmouth Safeguarding Children Partnership
Protecting Portsmouth's Children

This Serious Case Review has been completed by Tina Scarborough, Director for Quality and Safeguarding for Portsmouth Clinical Commissioning Group, an experienced nurse and midwife with specialist knowledge in safeguarding and safe sleeping.

The following agencies have contributed to this Serious Case Review:

- Portsmouth City Council Children's Services
- Portsmouth Hospitals NHS Trust
- University Hospital Southampton NHS Foundation Trust
- Solent NHS Trust
- Hampshire Constabulary
- GP Practice
- A Fertility Clinic

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1. Introduction

1.1. Based on statutory guidance[1] Portsmouth Safeguarding Children Board (PSCB) determined that it was appropriate to conduct a Serious Case Review (SCR) examining the circumstances around agency involvement with a 9 week old infant, who for the purposes of this report will be known as Child I.

1.2. Child I died aged 9 weeks having had no previously identified health concerns. The cause of death was unascertained; however Child I was found in an unsafe sleeping position co-sleeping with a parent.

1.3. Although prior to Child I's death there were no concerns for their safety and/or wellbeing; the case is subject to review as at the time of their death there was concern that Child I may have been subject to neglect, due to the circumstances in which they were found.

1.4. The aim of the Review is to capture areas of learning to inform improvements in advice and support given to new parents regarding safe sleeping and identification of factors that increase the risk to their infant should they chose to co-sleep with them. The review will also consider the treatment of and support provided to families following a death of a child.

2. Process for conducting the review

2.1 A referral for consideration of a Case Review was received by the PSCB in May 2018. Initially the Board felt that this case did not meet the criteria for a SCR. However, the National Panel challenged this decision on the basis that following Child I's death the parents had been arrested for neglect. Therefore they argued that the criteria as set out in Working Together 2015 had been met. As such the PSCB commissioned a concise SCR to examine issues concerning the welfare of Child I and the lessons to be learnt to improve experiences for children in similar circumstances in the future. Including the degree to which decisions were child focused and the effectiveness of working arrangements across agencies and services.

2.2 The Board commissioned Tina Scarborough, Portsmouth CCG Deputy Director of Quality & Safeguarding as the Independent Reviewer. The Board recognised that whilst the reviewer works in Portsmouth she had no involvement in this case; was not employed by any of the agencies involved in the review; nor had any line management responsibilities for the practitioners involved. To confirm that this would be acceptable in this case (as opposed to commissioning an Independent Consultant), the Board contacted the Secretariat of the National Panel who advised that it would be reasonable for Tina to be the reviewer in this case.

2.3 The approach taken has adhered with the principles as set out in statutory guidance[2]. A model of learning using systems ideas based on a Soft Systems Methodology[3] has been adopted. As such, the

[1] Working together to safeguard children, 2015, HM Government

[2] Statutory guidance expects case reviews to be conducted in a way that; recognises the complex circumstances in which professionals work together; 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; is transparent about the way data is collected and analysed; and makes use of relevant research and case evidence to inform findings.

[3] Soft Systems Methodology by Checkland, P., & Poulter, J., in Systems Approaches to Managing Change: A Practical Guide, Reynolds, M., & Holwell, S., Open University, 2010.

process has been able to capture and identify opportunities for professionals and organisations to learn and improve safeguarding practices from a whole system perspective.

2.4 Following the decision in October 2018 by the Independent Chair of the Board to commission this review the following steps were taken:

2.4.1 Terms of reference for conducting the review were set by the Case Review Committee (a sub-group of PSCB).

2.4.2 Single agency reports and chronologies were requested and submitted. This process provided each agency with the opportunity to reflect on their involvement with Child I and the family – from a single agency viewpoint but also from a wider, and more interactive systemic perspective. As a result, agencies have been able to consider actions required of themselves in order to make improvements to practice.

2.4.3 A facilitated multi-agency workshop which involved practitioners who had come into contact with Child I and the family.

2.4.4 Interviews with Child I's parents to ascertain their views and perspectives of the care and treatment they and Child I received from agencies as well as what changes they would want to see.

2.4.5 A further information gathering process led by the Independent Reviewer based on the observations and instructions of the review panel. This will be done through supplementary questions, interviews; multi-agency learning event(s) if appropriate; and engagement with the family.

2.4.6 Throughout the above steps, the Case Review Committee has maintained oversight of progress and activity, offering support and assistance when necessary.

2.5 It was agreed that the timeframe for the review would be from June 2017 to the date of Child I's death. Following initial information gathering and interview with Child I's parents, the scope of the review was extended to include the first three months following Child I's death to examine the support and treatment of Child I's family and identify learning to improve services for bereaved families. Relevant information prior to this timeframe is also included as necessary.

3. Family participation

3.1. Seeking the contribution of family members has been an important consideration. Both Child I's parents accepted the offer to engage in the review and their views are incorporated throughout. In particular the information shared by the parents regarding how they were treated by professionals and the support they received following Child I's death led to an extension of the time frame for the review to capture agency responses following Child I's death.

4. Summary of relevant case history: prior to the timeframe under review

4.1. Both parents had previously come to the attention of Police for alcohol related incidents. However, the dates of these occurrences were outside of the period of time considered by this review.

4.2. Mrs I was referred to an NHS fertility clinic. When a history was taken by the clinic in June 2016 Mrs I disclosed alcohol intake of 8 units per week and Mr I disclosed 15-20 units per week[4]. They were both advised to reduce their alcohol intake as part of pre-conception counselling[5].

4.3. Mr. and Mrs. I self-referred to a Fertility Clinic in March 2017 and were seen in April 2017. At this appointment both parents reported that they had stopped drinking alcohol and were non-smokers. Mrs. I underwent fertility treatment and had a positive pregnancy test in July 2017. She as then discharged from the Fertility Centre.

5. Practice episodes

5.1 In reviewing the multi-agency contact and involvement with Child I and the family, and now with the benefit of hindsight, three linked practice episodes emerge that warrant closer examination in order to further understand what happened, and why events occurred as they did at the time. These three episodes are significant in terms of Child I and their family, and how services engaged and supported them. As such, they provide us with the greatest insight into the quality and effectiveness of the response to Child I and the family. These episodes are:

1. Mrs I's pregnancy and delivery of Child I – June 2017 to 13 March 2018
2. Child I's life – 14 March to 20 May 2018
3. Treatment and support of the family following Child I's death – 21 May 2018 to 31 August 2018

Practice episode 1: Pregnancy and Birth of Child I – June 2017 to March 2018

5.2 Mrs I had a positive pregnancy test following her fertility treatment on 10 July 2017. The GP referred Mrs I to maternity services using the appropriate referral route. GP referral included alcohol intake as 'light drinker; 1-2 U/day'.

5.3 Mrs I subsequently attended a booking appointment with her Community Midwife on 30 August 2017 at around 12 weeks of pregnancy. National Institute for Health and Care Excellence (NICE) Guidelines[6] recommend that women should have a booking appointment with a midwife by 10 weeks of pregnancy. Mrs I did not present to her GP for the pregnancy until after 10 weeks so the booking appointment was undertaken as soon as practicable after presentation. The Guideline also recommends that lifestyle advice (including smoking cessation, recreational drug use and alcohol consumption) are discussed at this appointment. During the initial booking visit with the midwife,

[4]CMO Low Risk Drinking Guidelines https://www.drinkaware.co.uk/alcohol-facts/alcoholic-drinks-units/latest-uk-alcohol-unit-guidance/
[5] https://patient.info/healthy-living/alcohol-and-liver-disease/alcohol-and-sensible-drinking

[6] NICE Guidelines: Antenatal Care for Uncomplicated Pregnancies 2008 reviewed in Jan 2017 https://www.nice.org.uk/guidance/cg62

a full history was obtained. Both parents attended and were asked about smoking, neither had ever smoked. There was no disclosed history of substance or alcohol misuse or any psychiatric illness. There were no specific medical problems in either parent. Questions around domestic violence were not asked at booking as the midwife was unable to speak to Mrs. I alone. Alcohol usage at booking was described as a slight drinker 0- 1-2 u/day. Alcohol consumption pre- pregnancy was not recorded at booking or unit consumption calculated. It was recorded that no alcohol consumed now pregnancy confirmed and the GP referral letter recorded alcohol and units consumed as a light drinker. The parents were given a booking pack which contains information leaflets for parents including a safe sleep leaflet.

5.4 Mrs. I attended all antenatal appointments. There were some concerns around static growth at 34 weeks gestation and a growth scan was performed which showed no abnormal findings. Mrs. I was assessed as low risk and therefore would be suitable for birth in all settings. Mrs. I was booked onto Parent Craft classes at 31 weeks of pregnancy.

5.5 When the overview author met with Mr. and Mrs. I they reported that they weren't sure if they had had all the antenatal appointments they should have had. They recalled that they always saw a different midwife as there was a lot of sickness in the team. They were told by midwives at the time that this was unfortunate but Mrs. I did not know the name of her midwife. Better Birth 2016[7] states that there should be continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions. It goes on to say that every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatal. Mrs I was seen by at least 5 different midwives during the antenatal period and yet another different midwife in labour.

5.6 The Health Visitor (HV) carried out an antenatal contact visit at home when Mrs I was around 38 weeks pregnant. The HV discussed safe sleeping and gave Mrs. I the Lullaby Trust leaflet[8]. No mental health history or substance misuse was reported to the HV. The HV identified that Mrs. I and her then unborn baby were suitable for the Universal Healthy Child Programme[9] as no risks or concerns were identified. It was planned that a Community Health Nurse would visit in the postnatal period.

5.7 On 13 March 2018 at 02.40hrs Mrs I was admitted to Portsmouth Birthing Unit in spontaneous labour. An assessment was undertaken but the substance misuse and alcohol section on maternity paperwork was not completed so it is not known whether the assessment was undertaken or whether this is a recording issue.

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[7] National Maternity Review: Better Births 2016 https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[8] Lullaby Trust Leaflet - Safer sleep for babies: a guide for parents https://www.lullabytrust.org.uk/wp-content/uploads/Safer-Sleep-for-babies-a-guide-for-parents.pdf

[9] Universal Healthy Child Programme https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592893/Review_of_mandation_universal_health_visiting_service.pdf

5.8 Child I was born at 17.09hrs in excellent condition following a normal labour and delivery. Child I weighed 3100 grams and no abnormalities were seen at initial examination. Mr. and Mrs. I decided to bottle feed Child I using formula. The family were keen to go home and mother and baby were discharged home at 22:00hrs.

5.9 There is clear documentation that discharge information was given both verbally and re-enforced with written information prior to discharge home. This included 'Safe Sleeping', 'Cot Safety' and 'Car Safety' advice and relevant leaflets.

Practice episode 2: Child I's life – 14 March 2018 to 20 May 2018

5.10 On day one following Child I's birth a routine postnatal contact was undertaken by the Postnatal Coordinator (a senior Midwife). This contact was by telephone which is normal practice for low risk, well mothers and babies. Mrs I reported that both Child I and she were well. The Postnatal Coordinator documented that Child I slept on a 'snug pod' next to Mrs I. The Postnatal Coordinator reported that it is her normal practice to advise parents about the risks of using 'Snug Pods'[10] and that the safest place for baby to sleep is in a separate cot, crib or Moses basket but she did not document the advice she gave. Safe sleeping is documented as 'on back, feet to bottom'.

5.11 On day two Child I was bought to a routine postnatal contact with a Paediatrician for a newborn and infant physical examination (NIPE). The Paediatrician recorded one risk factor on the NIPE record "1st degree relative – heart abnormalities". Safeguarding concerns are recorded as none by clinician. Mild jaundice was noted so the Paediatrician contacted the Postnatal Coordinator requesting a further blood sample is taken on day three to check these levels again.

5.12 The original planned telephone contact to the family on day three was changed to a visit due to Child I being jaundiced. A home visit was attempted by Maternity Support Worker but she was unable to find the house. Alternative arrangements were made for Child I to attend Portsmouth Maternity Centre instead. Blood test taken as planned to check serum bilirubin levels. Mr. and Mrs. I were contacted by phone in the evening and informed that blood test results indicated that Child I required treatment for jaundice. Arrangements were made for the parents to bring Child I to the Children's Assessment Unit (CAU). On admission the children's admission and discharge form was completed by Mr. I who confirmed Child I did not have a social worker, that there was no Social Services involvement and that there were no issues with alcohol misuse, drug misuse, domestic violence or mental health conditions. The admitting nurse completed the safeguarding checklist on admission and recorded that there were no safeguarding concerns however she did not check the Child Protection – Information System (CP-IS)[11] on admission as per guidance.

5.13 On day four Child I and Mrs. I were transferred from the children's unit to the Maternity Unit. Phototherapy continued until Bilirubin levels steadily reduced and phototherapy was

[10] The Lullaby Trust issues warning about some popular baby sleeping products sold in high street stores Mar 2018 https://www.lullabytrust.org.uk/the-lullaby-trust-issues-warning-about-some-popular-baby-sleeping-products-sold-in-high-street-stores/

[11] Child Protection-Information System (CP-IS) https://www.england.nhs.uk/ourwork/safeguarding/our-work/cp-is/

discontinued. On day 5 Child I was feeding well and the bilirubin level had fallen below the level requiring treatment. Mother and baby were discharged home with a plan for the parents to bring Child I to the drop in clinic in the Children's Outpatient Department on Day 8.

5.14 On day 6 the Postnatal Coordinator completed a routine follow up phone call with the parents. No concerns were identified and an appointment was made for the following day at the Maternity Centre. Parents attended the planned appointment with Child I on day 7. All observations were within normal parameters and a further appointment was made for Day 9.

5.15 On day 8 Child I was due to attend Children's Outpatients for a follow up blood test but was not brought (WNB) for this planned medical test.

5.16 On day 9 Child I and the parents attended a routine clinic appointment with the Maternity Support Worker. Jaundice was resolving, the only concern was that Child I's weight gain was only 5 grams in two days in context of overall normal weight loss.

5.17 Child I and parents were seen by their named Community Midwife for discharge from Maternity Care on Day 15 following birth. Both Child I and Mrs. I were noted to be well and no concerns were identified. It was identified that Mrs. I had not had any contact from the Health Visiting Service and she was advised to contact her GP practice if still no contact within a week. The Midwife documented that 'cot safety and postnatal depression' was explained. During the practitioner event the midwife described the routine Cot Safety advice which included safe sleeping advice. The advice given included risks of co-sleeping especially when consuming alcohol or drugs and the risks of sleeping on a sofa.

5.18 On Day 18 a Junior Neonatal Doctor followed up on Child I's repeat blood test and identified that the repeat sample had not been taken as per plan. The doctor telephoned Child I's mother and confirmed neonatal wellbeing and determined that there was no need for a further blood test. The system for follow up of planned medical tests was effective.

5.19 A New Birth visit should be carried out between Day 10-14 days following birth to ensure a systematic handover of care from the midwife to the Health Visitor. It also enables the health visiting team to identify any needs or risks in the early postnatal period. Due to an administrative error, the New Birth visit by the Health Visiting Service was not carried out in a timely manner. A community health nurse was sent to visit on day 50 with no answer achieved as the wrong house was attended and so returned on day 57 to the correct house. Due to this delay, the risks of co-sleeping could not be reiterated in a timely manner during the postnatal period.

5.20 Child I and Mrs. I were seen by their GP when Child I was six weeks old. There is nothing of note at this appointment relevant to the review.

Practice episode 3: Child I's death 20 May 2018 to 30 August 2018

5.21 Child I's parents describe having a day out with friends which included a Garden Party to watch a national event and a significant football match. They were drinking alcohol throughout the day. On return home in the evening Mrs. I settled on the sofa with Child I on her chest and fell asleep. Mr. I went out for a curry and when he returned he saw both Child I and Mrs. I asleep on the sofa. Mr. I

then went to bed leaving Child I on Mrs. I's chest sleeping on the sofa. Several hours later Mr. I awoke and went to check on them and move Child I into the cot.

5.22 Mr. I found Child I still with Mrs I, who was asleep on the sofa. Child I was cold and lifeless. Mr. I woke Mrs. I who commenced resuscitation and called an ambulance. The ambulance service alerted the Police. Mr. I went with Child I in the ambulance to the nearest emergency department and Mrs I followed shortly after in her own car.

5.23 Paramedics pre-alerted the Emergency department that they were coming with a 9 week old baby in cardiac arrest. Child I was pronounced dead at 02.05 after full team discussion at bedside.

5.24 The Emergency Department initiated their normal process following the death of a child which includes:

- Parents/carers are given the following leaflets/booklets:
  - 'When your baby/child dies in the ED' (PHT)
  - 'The Child Death Review'
  - Bereavement Support Card (Lullaby Trust)
  - 'When a Baby dies Unexpectedly'
  - Post Mortem Examination (NHS)
  - How to make a Memory Box
- Parents/ carers are asked if they would like items for their memory box such as a wisp of hair, handprints, footprints and photographs.
- Parents/carers are invited to come back and meet with a senior doctor and nurse around six weeks after the death. This is known as a 'bereavement meeting' and is usually an opportunity for parents to ask any questions they have and to receive information from the medical team about investigation results, post mortem results etc. Further signposting also occurs at this meeting as needed.

5.25 During resuscitation Mrs I made significant statements regarding feelings of guilt to hospital staff and police. Both health staff and police identified that Mrs I was clearly still under the influence of alcohol and smelt strongly of alcohol.

5.26 Two hours following Child I's death Mrs I was arrested at hospital in relation to driving with excess alcohol. Mr. I was arrested the following day as further detail had been established. Mrs I was further arrested once in custody for neglect. They were both taken into custody. Following interview Mrs I was seen by the Liaison and Diversion Service (L&D)[12]. She was referred to L&D engagement workers for ongoing support and her GP was informed. Mrs I was given L&D contact details and bereavement counselling contact details

[12] Liaison and Diversion (L&D) services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders.
The service can then support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.

5.27 A multi-agency initial meeting under the Portsmouth Safeguarding Children Board Child Death procedure was held the day after Child I died. This was led by police due to the criminal investigation. The following professionals attended:

- Acute Hospital's Safeguarding Specialist
- South Central Ambulance Service (SCAS)
- Emergency Department
- Community Trust NHS Safeguarding Service/Rapid Response Nurse
- Health Visiting

5.28 There is no evidence that the GP or the fertility clinic were invited. The Community midwife was on leave so the Community Liaison Midwife (CLM) was contacted. A decision was made that as the CLM had not had any contact with Mrs I or Child I and the maternity notes had not yet been obtained that there would be no value in her attending.

5.29 Ongoing support for Child I's parents was discussed and it was agreed that support would be provided by the Police Officer assigned to support the family. Consideration was given to whether the criminal investigation would have an impact on this and it was agreed that this could be revisited if the relationship deteriorated. It is normal practice following a child death for the multi-agency team to look to professionals already working with the family to provide ongoing support, as they are already known to them. In this case there were no other agencies working with the family.

5.30 The GP practice received a call from L&D the day following Child I's death expressing concerns for Mrs I's welfare. At this time she was staying with her parents. She was offered an appointment at the surgery, and advised that alternatively she could be seen at her parents GP surgery if necessary.

5.31 The Emergency Department wrote to Child I's parents as part of their routine response inviting them to meet as per 5.24 above. The family did not respond to the letter.

5.32 Child I's parents contacted the fertility clinic 11 days following the death to inform them that Child I had died from 'SIDs' and to enquire about their saved embryos. The family was offered counselling by the service.

5.33 Two weeks following Child I's death Mr. I made an appointment with his GP and both parents attended. Mrs. I was tearful, and appeared shocked. She did not speak much. The GP offered for her to make another appointment for herself when she felt ready to talk about how she was feeling. Mr. I spoke about the recent events and was clearly and appropriately distressed. He reported that he had been advised by the police to "see your GP" for counselling, but had already made contact with the Lullaby Trust charity for support, and been offered counselling through the fertility clinic. This support was also available to Mrs I. The option of local NHS counselling services was discussed but was not taken up.

5.34 A multi-agency intermediate meeting under the Portsmouth Safeguarding Children Board Unexpected Child Death procedure was held two weeks after the initial meeting. This was led by police due to the ongoing criminal investigation. The following professionals attended:

- Police
- South Central Ambulance Service (SCAS)
- Emergency Department
- Community Trust NHS Safeguarding Service/Rapid Response Nurse
- Health Visiting

5.35 There is no evidence that the fertility clinic or the community midwife had been contacted. It is noted that support for the family is not specifically discussed and there is a clear request by police that they would prefer for the family not to be contacted while the police investigation was ongoing. Police requested that if professionals needed to contact the family, this should be done through the police first.

5.36 Six months following Child I's death his parents attended a fertility clinic for frozen embryo transfer which was successful. The clinic followed the Human Fertilisation & Embryology Authority Code of Practice [13] which states that fertility centres should take a medical and social history from each patient and their partner. The centre did not seek confirmation from other professionals regarding the circumstances around Child I's death and accepted the parent's explanation. At the time of the frozen embryo transfer there was still an open ongoing police investigation.

6. Findings & analysis

6.1 This SCR is unusual in that there were no concerns about the parent's care of Child I prior to the death and there is evidence that Child I was a much loved, healthy child. The issue which has led to this SCR is the sleeping arrangements on the night that Child I died. On that night Mrs I fell asleep on the sofa with Child I - often referred to as "co-sleeping". The research has suggested that perhaps half of the mothers in the UK co-sleep with their baby at some time[14]. However it is clearly evidenced that there is an association between co-sleeping and Sudden Infant Death Syndrome (SIDS). Consequently the Department of Health[15] has advised that parents/carers should never sleep with their baby on a sofa or armchair and 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

[13] Human Fertilisation & Embryology Authority, Code of Practice 9th Edition 2018. https://www.hfea.gov.uk/media/2793/2019-01-03-code-of-practice-9th-edition-v2.pdf The Human Fertilisation and Embryology Act 1990 ('the Act') covers the use and storage of sperm, eggs and embryos for human application, as well as all research involving the use of live human and admixed embryos. The Code of Practice contains regulatory principles for licensed centres, and guidance notes which provides guidance to help clinics deliver safe, effective and legally compliant treatment and research.

[14] Blair PS and Ball HL (2004). The prevalence and characteristics associated with parent-infant bed-sharing in England. Arch Dis Child 89:1106-1110
Attitudes and experiences of bed-sharing in Northeast England
http://adc.bmjjournals.com/cgi/content/abstract/89/12/1106?ct%20

[15] https://www.nhs.uk/conditions/pregnancy-and-baby/reducing-risk-cot-death/

- may be extremely tired

6.2 The Triennial Review of Serious Case Reviews 2011 -2014[16] examined 31 cases of Sudden Unexplained Deaths of Infants (SUDI). Most of these children died while co-sleeping with a parent or in other dangerous sleeping arrangements, such as on a sofa, on soft bedding, or in make-shift bedding. Substance and alcohol misuse was common, as were parental mental health concerns.

6.3 This section of the overview report distils the key areas for analysis whilst also noting learning points for practice. The relevance of the above practice episodes will now be explored by way of an appraisal about the effectiveness of the multi-agency safeguarding system.

How family history informs assessments and decision making

6.4 This section will look at how previous risk factors were identified and what assessments were undertaken.

6.5 There were a number of routine assessments of Child I and the parents. Initially Mr. and Mrs. I were referred to a fertility clinic by their GP. The clinic undertook an assessment and identified that at that time both parents disclosed alcohol use with Mrs I reporting a consumption of 8 units of alcohol per week. This is within guidelines for women not planning a pregnancy. Studies show that drinking between one and five drinks a week can reduce a women's chances of conceiving, and 10 drinks or more decreases the likelihood of conception even further[17]. The clinic advised both parents to reduce their alcohol intake.

6.6 When a newly pregnant woman presents to their GP the GP undertakes an initial assessment and refers the woman to the midwife. The referral form includes health and social questions e.g. alcohol intake, domestic abuse. The GP completed the referral in this case and identified that Mrs I was now reporting that she was a light drinker and that there was no domestic abuse.

Practice Note
Routine enquiry into domestic violence and abuse is Department of Health policy in maternity and adult mental health services. Health practitioners are in a key position to identify domestic abuse and to initiate support and safety for victims.

People experiencing domestic abuse are more likely to come into contact with health services than other public services. As a health professional you will be a first point of contact for many. You have a responsibility to:

- know and recognise the risk factors, signs, presenting problems or conditions, including the patterns of coercive or controlling behaviour associated with domestic abuse
- facilitate disclosure in private without any third parties present; to be attentive and approachable; and use selective, and routine enquiry in pregnancy or where there are mental health concerns

[16] Depart for Education Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-_Pathways_to_harm_and_protection.pdf

[17] K Anderson, V Nisenblat & R Norman 2010; 'Lifestyle factors in people seeking infertility treatment – A review'. Australian and New Zealand Journal of Obstetrics and Gynaecology, Vol.50, Issue 1, pp8—202

6.7 At booking, the midwife also undertakes an assessment which informs the planned care in pregnancy and beyond. Routine questioning around domestic abuse was not undertaken at booking as Mr. I was present. Whilst domestic abuse is not a known feature in this case National Institute for Health and Care Excellence (NICE) Guidelines recommend women should be given the opportunity to disclose domestic violence in an environment in which they feel secure. Routine questioning was never undertaken by maternity services during the care provided to Mrs. I and Child I. Routine enquiry into domestic violence and abuse is Department of Health policy in maternity services[18]. This may have been impacted by staffing issues in maternity services as at the time. Mrs. I saw five different community midwives during pregnancy.

6.8 There is evidence to suggest that both men and women significantly under estimate the amount of alcohol they drink up to as much as 60%. There is also evidence to suggest that even those who report zero or occasional alcohol use may drink up to double the weekly recommended number of units on one occasion/session particularly during a celebration[19]. Whilst Child I's parents were asked about alcohol consumption there is no evidence that the nature of drinking and number of units consumed was fully explored. This is especially important when exploring 'Safe Sleeping' arrangements as risk factors may alter on a one off occasion.

6.9 The health visiting service carried out an antenatal visit during pregnancy and undertook a routine assessment of the family's social and medical history. The Health Visitor did undertake routine enquiry into domestic abuse. No concerns were identified and the family was recommended for Universal Healthy Child Programme.

6.10 Further routine assessments were undertaken when Child I was born and on admission to hospital for jaundice. No significant concerns were identified.

[18] Department of Health, Responding to Domestic Abuse: A resource for health professionals 2017 https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals

[19] Alcohol consumption higher than reported in England https://www.ucl.ac.uk/news/2013/feb/alcohol-consumption-higher-reported-england

6.11 When Mr. and Mrs. I attended the fertility clinic following Child I's death they were asked to complete a routine form to assess social risks and risks to the unborn baby. The fertility clinic accepted the parent's report that Child I died from Sudden Infant Death Syndrome and did not check this further.

Practice Note:
As per HFEA[13] CoP 8.3 The Fertility Centre should assess each patient and their partner (if they have one) before providing any treatment and should use this assessment to decide whether there is a risk of significant harm or neglect to any child.

As per HFEA CoP 8.5: The centre should repeat the assessment if:

a) the centre has been out of contact with the patient for two years or more;
b) the patient has a new partner;
c) a child has been born to the patient since the previous assessment; or
d) the centre has reason to believe that the patient's medical or social circumstances have changed significantly

As per HFEA CoP 8.16: The centre should obtain consent from the prospective patient (and their partner if they have one) to approach any individuals, agencies or authorities for any factual information required for further investigation if:

a) information provided by the patient (and their partner if they have one) suggests a risk of significant harm or neglect to any child;
b) the patient (and their partner if they have one) has failed to provide any of the information requested;
c) the information the patient (and their partner if they have one) has provided is inconsistent; or
d) there is evidence of deception.

Effectiveness of professional support and interventions and any barriers

6.12 This section will include advice on safe sleeping arrangements for babies and information to parents on what factors increase the risk to a baby when co-sleeping; what support was provided to the family, including bereavement support following the infant's death; recognition of children(s) and parents views, wishes and feelings and how these had been taken into account; difficulties experienced by professionals and whether/how these were overcome.

6.13 In 2007 Portsmouth agencies joined together to deliver the "Safer Portsmouth Babies" Campaign which was a public awareness campaign to reduce the risk of Sudden Infant Death. In 2008/09 there were no Sudden Infant Deaths in Portsmouth. This was followed up in 2009 with a further campaign across Hampshire.

6.14 PSCB has undertaken two previous Serious Case Reviews following a death of an infant in an unsafe

sleeping environment in 2011[20] and 2012[21]. One of the recommendations from those SCRs was "The Portsmouth Safeguarding Children Board should support the renewed delivery across all partner agencies of initiatives to promote "safe sleep"." This led to a further push to ensure parents are regularly given messages about safe sleeping. Child I is the first death in Portsmouth since then linked to unsafe sleeping arrangements.

6.15 It is clear from this review that safe sleeping messages were given consistently at least twice in the antenatal period (parenting classes and by the health visitor). These were repeated at least four times after Child I was born. The Midwife on day 1 gave specific advice regarding use on 'snug pods'. Advice was also given regarding the risks associated with the use of alcohol and co-sleeping.

Practice Note

Practitioners working with families should take every opportunity to remind parents of key safe sleeping messages tailored to their needs. These messages should include:

- The safest place for your baby to sleep is a separate cot or Moses basket in the same room as you for the first 6 months, even during the day
- Never sleep on a sofa or armchair with your baby, this can increase the risk of SIDS by 50 times
- Always put your baby on their back for every sleep, day and night, as the chance of SIDS is particularly high for babies who are sometimes placed on their front or side
- If you or your partner smokes while you're pregnant or after your baby is born, the risk of SIDS is greatly increased
- The safest mattresses for your baby are firm and flat and protected by a waterproof cover
- It is safest to keep baby's cot clear of any items such as bumpers, toys and loose bedding. Unnecessary items in a baby's cot can also increase the risk of accidents

6.16 During the practitioner event held in relation to this review the Health Visitor explained that she had given specific advice regarding the risk of sleeping on a sofa as she identified that Mr and Mrs I had a large corner sofa that would be tempting to sleep on.

6.17 During the period under review there was sickness within the midwifery team which led to Mrs I being seen by 5 different midwives. This is likely to have impacted on the relationship between the midwives and Mrs I which could have had an impact on how public health messages including safe sleeping are received. Mrs I then saw yet another midwife at delivery and then different people in the postnatal period. There is no evidence that continuity of care was considered during

[20] Child C: A Serious Case Review Executive summary 2011 http://portsmouthscb.org.uk/wp-content/uploads/Child-C-Executive-Summary-public-v4.pdf
[21] Child D: A Serious Case Review Executive summary 2012 http://portsmouthscb.org.uk/wp-content/uploads/Child-D-Executive-Summary-FINAL-190913.pdf

this time period.

Practice Note

Some parents choose to bed share with their babies. The following advice should be given to parents who choose to co-sleep:

- Keep pillows, sheets, blankets away from your baby or any other items that could obstruct your baby's breathing or cause them to overheat. A high proportion of infants who die as a result of SIDS are found with their head covered by loose bedding.
- Avoid letting pets or other children in the bed
- Make sure baby won't fall out of bed or get trapped between the mattress and the wall

Never co-sleep if:

- Either you or your partner smokes (even if you do not smoke in the bedroom)
- Either you or your partner has drunk alcohol or taken drugs (including medications that may make you drowsy)
- You are extremely tired
- Your baby was born premature (37 weeks or less)
- Your baby was born at a low weight (2.5kg or 5½ lbs or less)

6.18 Due to an administration error Child I and Mrs I were not seen by the health visiting team until over 50 days after birth. This may have impacted on how support was perceived especially after Child I's death. A visit was undertaken as soon as the error was identified. Maternity services had given advice to Mrs I that if she had not had contact from the health visitor within one week of discharge she should contact the GP.

6.19 Following Child I's death the 4LSCB Child Death Procedures were initiated led by police due to the criminal investigation. There is no date on the 4LSCB child death procedures so it is unclear when they were last reviewed or when they are due for an update. The current procedure advises that a home visit "should almost always take place for cases of sudden infant death, and where possible the visit should be undertaken jointly by the lead police investigator and specialist nurse". Whilst a home visit was undertaken by a police no other professional attended the family home following Child I's death. There was no discussion or consideration at the Initial meeting that a further home visit should be considered with the Specialist Nurse.

6.20 It was agreed at the initial meeting that the police contact officer would provide support to the family. There appears to have been no consideration about how the family may feel about the police also being their key worker as well as investigating concerns regarding a criminal investigation. It is likely that the criminal investigation prevented other professionals from contacting the family.

6.21 The family reported that they felt abandoned by professionals following Child I's death. They received a condolence card from a Health Visitor they had only met once but would have preferred either a phone call and/or a visit. It is recorded in the Rapid Response Phase 2 minutes that Solent NHS Trust would be conducting an "internal investigation for this case to highlight any potential learning". Police confirmed they would prefer for the family not to be contacted while the police investigation is running. If they would like to contact the family, this should be done through the police first". Nobody ever checked with the investigation whether contact could be made. It is unclear whether professionals interpreted this as meaning they could not contact the family to provide bereavement support.

Practice Note

The Lullaby Trust provide advice on supporting a bereaved family. They state *"most importantly, make contact, don't avoid it. When hearing of a bereavement many people, including friends and relatives, stay away, so even a two minute call will be appreciated. You don't need a counselling qualification or special training, just a good ear."*

Do:

- Keep it brief
- Say how sorry you are
- Use the baby's name
- Ask if there is anything you can help with immediately according to your professional capacity
- Offer future availability
- Check they have information about The Lullaby Trust, especially the bereavement support number
- Leave your own contact number

Don't:

- Use any clichéd expressions of condolences such as 'time's a great healer' etc.
- Ask them to repeat the story unless they are eager to do so

Providing a snap shot of service delivery at the time

6.22 This will look at staffing levels at the time and supervision and support available to staff as well as how staff have been supported following Child I's death and through the Serious Case Review Process; information available at the time; rationale for decisions; and management and supervision support available.

6.23 Better Births[22] identified that every woman should have a midwife, who is part of a small team of 4 to 8 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally. Mrs. I was seen by at least 6 different

[22] National maternity Review: Better Births Improving Outcomes of Maternity Services in England *A five year forward view of maternity care* 2016

midwives in the antenatal period due to sickness and a number of different staff postnatally including at least one Maternity support worker and several midwives. It is reported that she was discharged by her named community midwife but it is unclear whether she had been seen by her Named Midwife at any point during the antenatal period.

6.24 Despite policies in place and training programs for midwives regarding routine questioning for Domestic Abuse, Mrs I was never asked about her experiences of domestic abuse. Whilst Domestic abuse is not a feature in this case it is important to recognise that this should be a well-embedded part of routine antenatal care.

Practice Note

The risk of experiencing domestic violence or abuse is increased if someone:

- is female
- is aged 16–24 (women) or 16–19 (men)
- has a mental health problem (Trevillion et al. 2012)
- is a woman who is separated (Smith et al. 2011) – there is an elevated risk of abuse around the time of separation (Richards 2004)
- The risk is also increased if a woman is pregnant or has recently given birth

In addition, there is a strong correlation between postnatal depression and domestic violence and abuse.

6.25 Staff involved in this case were up to date with their safeguarding children and adult training and are reported to have attended domestic abuse training. There is no evidence that they discussed this case in supervision but there were not any apparent concerning features that would have led staff to seek supervision. There is no evidence of routine safeguarding supervision for midwives involved in this case at the time however the acute trust has now developed a safeguarding supervision system.

Practice Note

Five main functions of safeguarding supervision

- Clinical / reflective practice - critical evaluation of the assessment and planning for child and family
- Managerial – To ensure competent and accountable performance, management and practice appropriate for the professional role
- Developmental - To ensure continuous professional development
- Supportive – To provide personal support for effective performance and offer help to manage any personal impact of their work
- Advocacy – This may involve negotiations around roles and responsibilities and management of resource implications. It also includes escalation of concerns in relation to individual cases

6.26 Mrs. I was seen appropriately by Health Visiting services in the antenatal period and no concerns were identified. She was placed appropriately on the universal pathway. The Health Visitor, during the practitioner workshop, described how she gave specific advice to Mr. and Mrs. I regarding the risks of co-sleeping on a sofa. This included a conversation related specifically to the family's large corner (L-shaped) sofa as she had identified that there was a risk of accidently falling asleep with a baby on that style of sofa.

6.27 The Universal Health Visiting pathway in Portsmouth is primarily delivered to families by Community Health Nurses at home and in Family Hubs across the city. The initial antenatal contact is undertaken by a Health Visitor who decides, following assessment, which pathway would be the most appropriate. The 5 universal contacts are offered from pre-birth to 2 years and include a new birth visit 10-14 days. Mrs. I and Child I did not have a new birth visit until 57 days following Child I's birth. This is reported to be due to administration error on the electronic patient record (System One). It is however important to recognise that both the Health Visitor and Midwife had advised Mrs. I how to contact a Health Visitor and when a visit should have been expected.

Consideration of the effectiveness of multi-agency working

6.28 This section will review communication between agencies; escalation of concerns; quality of information on which the decisions were based; and consideration of options to manage or mitigate the risk identified.

6.29 Mrs I had a positive pregnancy test following her fertility treatment in 10 July 2017. The clinic advised Mrs I. that it was her responsibility to inform her GP. She did not present to her GP for the pregnancy until after 10 weeks so the booking appointment was undertaken as soon as practicable after presentation. There is no requirement in the HFEA guidelines for the fertility clinic to inform the GP of the successful fertility treatment. The process of referral to maternity services may have been timelier if it were standard practice for a fertility clinic to either inform maternity services direct or the GP, rather than be reliant on the mother presenting to the GP in a timely manner.

6.30 Once the pregnancy was known to the GP Mrs I was promptly referred to maternity services using the correct referral form and was seen by a midwife quickly.

6.31 There were some concerns around static growth at 34 weeks gestation and appropriate action was taken to investigate this concern. A growth scan was performed which showed no abnormal findings.

6.32 The HV discussed safe sleeping and gave Mrs I the Lullaby Trust leaflet during her antenatal visit and identified risks related to accidentally falling asleep on the family's large sofa. Appropriate action was taken and specific advice given to Mrs I around safe sleeping.

6.33 Child I was admitted to the Children's Assessment Unit (CAU) due to jaundice. This was an appropriate action following detection of jaundice that required treatment. The admitting nurse completed the safeguarding checklist on admission and recorded that there were no safeguarding concerns however she did not check the Child Protection – Information System (CP-IS) on admission as per guidance.

Practice Note

The CP-IS project is linking the IT systems used across health and social care and helping organisations to change business processes so this basic information can be shared securely between them. The information can only be accessed securely by trained professionals involved in a child's care. When a child is known to social services and is a Looked After Child or on a Child Protection Plan, basic information about that plan is shared securely with the NHS. If that child attends an NHS unscheduled care setting, such as an emergency department or a minor injury unit:

- the health team is alerted that they are on a plan and has access to the contact details for the social care team
- the social care team is automatically notified that the child has attended, and both parties can see details of the child's previous 25 visits to unscheduled care settings in England

6.34 When Child I was not bought for a follow up blood test the episode was recognised and appropriately managed in a timely manner.

6.35 The Child death process will be examined in detail in the next section but there is evidence of good communication between paramedics, police and the emergency department during the initial emergency.

6.36 Following Mrs I's arrest the police identified that she was distressed and she was appropriately referred for assessment by the Liaison and Diversion Service.

6.37 When Mr and Mrs I attended the fertility clinic following Child I's death history was taken but the fertility clinic did not undertake any checks to verify the significant information the family had shared regarding Child I. At the time of the frozen embryo transfer there was still an open ongoing police investigation which the clinic were unaware of as they had not done any checks.

Consideration of the effectiveness of Multi-Agency practice to support families following the unexpected death of a child

6.38 The section will review police processes, 'Rapid Response', how agencies communicated and supported each other and their staff, support offered to family and the wider community, and impact on any future pregnancy.

6.39 The 'Rapid Response' Process was initiated as per the 4LSCB Unexpected Child Death Procedures[23]. However there are no review dates on the procedures so it is unclear when they were published or last reviewed and updated.

6.40 As per the protocol the ambulance service responded promptly to the 999 call and followed procedures by alerting the police and local emergency department. The paramedics took all appropriate actions at the scene and promptly transferred Child I to hospital.

6.41 The Emergency Department initiated their normal process following the death of a child which

[23] 4LSCB Rapid Response Procedure.
https://www.proceduresonline.com/4lscb/shared_content_scb_php/shared_files/rapid_response.pdf

supports the 4LSCB procedures (see 5.24 for details). The process was complicated by Mrs I making significant statements to both hospital staff and police which led to her subsequent arrest in the emergency department.

6.42 The police custody record showed that a risk assessment was undertaken on arrival in custody and police acted appropriately to provide support by ensuring that Mrs I was seen by the custody nurse and had access to legal advice. They also referred appropriately to the Liaison and Diversion Service. The police also ensured that Mrs I had contact details for the Liaison and Diversion Service and bereavement counselling. They further ensured that Mrs I had support by arranging for her to be collected from custody by family members.

6.43 A multi-agency initial meeting under the Portsmouth Safeguarding Children Board Child Death procedure was held the day after Child I died. This was led appropriately by police due to the criminal investigation. There was an opportunity here to involve the GP and the fertility clinic that was not done. As part of multi-agency working it would have been best practice to engage with those professionals who had had most involvement with the family and also may provide future support for the family.

6.44 Ongoing support for Child I's parents was discussed and it was agreed that support would be provided by the Police Contact Officer. Whilst consideration was given to whether the criminal investigation would have an impact on this, no consideration appears to have been made that it is normal practice following a child death for the multi-agency team to look to professionals already working with the family to provide ongoing support, as they are already known to them. In this case there were no other agencies working with the family but given the police investigation it may have been more appropriate to ask the GP, Health Visitor or the Rapid Response Nurse to undertake this role.

6.45 Working Together 2015[24], 4LSCB Rapid Response Procedures[25] and the Royal College of Paediatricians and Child Health (RCPCH)[26] all state that in almost all cases of sudden infant death, a home visit should be undertaken jointly by the lead police investigator and specialist nurse. The purpose of this visit is to obtain further, more detailed information about the circumstances and environment in which the infant died, and to provide the family with information and support. This visit should normally take place within daylight hours. If there is likely to be a delay in arranging the joint visit, the police investigator should consider whether the police should carry out an initial visit to review the environment, ascertain whether there are any forensic requirements and appropriately record what is found. Unless there are clear forensic reasons to do so, the environment within which the infant died should be left undisturbed so that it can be fully assessed jointly by the police and health professionals, in the presence of the family.

6.46 There is no evidence in the minutes from either the multi-agency initial meeting or the intermediate

[24] Working together to safeguard children, 2015, HM Government
[25] 4LSCB Rapid Response Procedure.
https://www.proceduresonline.com/4lscb/shared_content_scb_php/shared_files/rapid_response.pdf
[26] RCPCH Sudden Unexpected Death is Infancy and Childhood: Multi-Agency Guidelines for Care and Investigation 2016

meeting that a home visit was undertaken or even considered. During the practitioner event it was confirmed that a home visit was undertaken by the police alone shortly after the parents were arrested. Despite all the guidance clearly identifying that a home visit should be undertaken within 24 hours (usually the same day) or if the circumstances of the death are suspicious and a criminal investigation has commenced, it will be essential to preserve the scene of the child's death and a joint visit may not be appropriate. If this is the case then a second joint visit should then be arranged at the earliest opportunity. One of the purposes of the home visit including health professionals is to provide information and support. Unfortunately in this case this did not happen and the family have reported to the reviewer that they did not feel adequately supported by professionals.

6.47 There is evidence of good liaison between the L&D Service and the GP practice to support Mrs I's welfare. The GP practice responded well by offering an appointment and signposting to an alternative if not convenient.

6.48 Mr and Mrs I were offered support and counselling by a range of agencies including Police, L&D Service, GP and the Fertility Clinic. They were also provided with details of the Lullaby Trust who specialise in providing support to families in this situation. The emergency department also wrote to Child I's parents as part of their routine response inviting them to a bereavement meeting as per 5.24 above.

6.49 A further multi-agency intermediate meeting under the Portsmouth Safeguarding Children Board Unexpected Child Death procedure was undertaken two weeks after the Initial meeting. There is no evidence that the fertility clinic or the community midwife had been contacted. There was a clear request by police that they would prefer for the family not to be contacted while the police investigation was ongoing. It is likely that this prevented other professionals from feeling able to contact the family to offer support.

6.50 As identified above, when Mr and Mrs I attended the fertility clinic following Child I's death a history was taken but the fertility clinic did not undertake checks to verify the information the family had shared regarding Child I. This was further exacerbated by the lack of involvement in the Rapid Response Process by the GP and fertility clinic as they were not invited to the meetings and their views were not adequately sought.

6.51 It became evident during the practitioner event that not all staff had been well supported following Child I's death and the subsequent Case Review process. For example the Community Midwife had not been informed of Child I's death and the subsequent Serious Case Review until shortly before the practitioner event. This meant that the Community Midwife had not been prepared for the event and had not had opportunity to review her notes. The PSCB Serious Case Review and learning Review Procedure[27] states that the death of a child is likely to be a traumatic event for practitioners involved, particularly if they were involved in service delivery to the child or to the child's family. Managers have a duty of care to employees and volunteers and should ensure that where there is a SCR all staff involved are offered support through the SCR process. NSPCC and SCIE Serious Case

[27] PSCB Serious Case Review and learning Review Procedure 2015 http://portsmouthscp.org.uk/wp-content/uploads/PSCB-SCR-PROCEDURE-FINAL.pdf

Review Quality Markers[28] state that SCRs can be frightening and threatening and employers have a duty of care to all staff, which requires them to provide adequate support. Individual learning is also enhanced by practitioners having a positive experience of contributing to the SCR.

Practice Note

The death or serious injury of a child is likely to be a traumatic event for practitioners involved. Practitioners and managers who were involved in the case are an important source of information for an SCR. Their input is critical to understanding why individuals acted as they did and what was influencing their practice. How they experience being involved is important:

- SCRs can be frightening and threatening and employers have a duty of care to all staff, which requires them to provide adequate support. This may include provision of support from the employer or by giving advice about sources of independent support. Individual learning is enhanced by practitioners having a positive experience of contributing to the SCR
- The broader learning and improvement culture of an organisation is strengthened by good feedback from practitioners who have been constructively involved in an SCR

6.52 The PSCB Serious Case Review and learning Review Procedure was last reviewed June 2015 and was due for review in June 2017. This review has not taken place.

7. Good Practice

7.1 The focus of this review is to learn and improve services. As such, it is important to capture good practice which supports outcomes for children. Many examples of good professional practice have been highlighted and a selection are summarised below.

7.2 Portsmouth has had two previous SCRs[29] related to unsafe sleeping environments. Recommendations from these reviews included ensuring parents are given safe sleep messages during the pregnancy and postnatal period. It is good to see in this case that Child I's parents were given clear and consistent messages throughout pregnancy and Child I's life regarding safe sleeping. This started at booking with the distribution of the Lullaby Trust booklet on safe sleeping and included specific intervention by the health visitor at the antenatal visit regarding the family's sofa and later by the midwife when the parents were using a snug pod.

7.3 Despite staffing challenges due to staff sickness, Mrs I was discharged by her named community midwife which is good practice. A named community midwife who knows the mother is well placed to assess wellbeing and mood.

7.4 When Child I was not brought for a repeat blood test for jaundice this was followed up robustly by the neonatal doctor which demonstrates robust processes for following up planned medical tests.

[28] NSPCC and SCIE Serious Case Review Quality Markers 2016 https://www.proceduresonline.com/4lscb/shared_content_SCB_php/shared_files/scr_quality_markers.pdf

[29] Child C: A Serious Case Review Executive summary 2011 http://portsmouthscb.org.uk/wp-content/uploads/Child-C-Executive-Summary-public-v4.pdf

Child D: A Serious Case Review Executive summary 2012 http://portsmouthscb.org.uk/wp-content/uploads/Child-D-Executive-Summary-FINAL-190913.pdf

7.5 The paramedics, police and emergency department responded quickly to Child I when he was found unresponsive. The Emergency Department had robust process in place to support family and practitioners when a child dies and these were initiated appropriately.

7.6 The emergency department had recently facilitated training for their staff regarding responding to the unexpected death of a child. This was delivered by Hampshire police. It was highlighted in the review how well the Joint Agency Response had gone between police and medical staff.

7.7 There was good communication between the police, hospital staff, Hampshire Liaison and Diversion Service and the GP after Child I died.

7.8 The Police Contact Officer built a good relationship with the family despite the difficult circumstances where there is an ongoing criminal investigation.

7.9 There is evidence of good liaison between the L&D Service and the GP practice to support Mrs I's welfare. The GP practice responded well by offering an appointment and signposting to an alternative if not convenient.

8. Conclusion

8.1 This Serious Case Review has examined the circumstances in which Child I died. It has gathered documentary information from agencies and organisations involved with Child I and the family. The review has concluded that the death of Child I was neither predictable nor preventable by any of the agencies involved.

8.2 The Review has highlighted many aspects of good practice and evidence of learning from previous Serious Case Reviews having been embedded into practice.

8.3 The Review has also highlighted some areas where practice can be improved, especially around conversation with families about alcohol consumption and planning for occasions when they may drink alcohol.

8.4 Specific learning and recommendations from this review are summarised below.

9. Recommendations

The following recommendations are provided to further strengthen practice around the areas identified. They are divided up under the agencies they relate to.

Portsmouth Safeguarding Child Partnership

Recommendation 1

The PSCP to promote the learning from this review across all relevant partner agencies, and seek assurances that it has been disseminated and specific single agency recommendations have been embedded.

Recommendation 2

PSCP in partnership with the Hampshire, IOW, Southampton and Portsmouth (HIPS) group to review the Child Death procedures to take into account the learning from this review and the

changes in national guidance. The new procedures should include the following from this review:

- All procedures must include date ratified and date due for review
- Clear guidance on who should be invited to meetings to include fertility clinic and maternity staff where appropriate
- Ensure that the importance of joint home visits is highlighted and embedded into practice
- Support for families is considered even when there is a criminal investigation ongoing

Recommendation 3

The PSCB Serious Case Review and Learning Review Procedure was last reviewed in June 2015 and was due for review in June 2017. PSCP should review and update this procedure as soon as possible. It should clearly identify expectations related to how agencies support staff involved in Case Reviews and Serious Child Care Incidents.

Recommendation 4

Consider how PSCP supports the workforce in working with universal and high risk families to identify safe-sleep risks, with an emphasis on 'out of routine' events such as staying at a relative's house, going on holiday, attending a party where they may drink more than usual etc. and then supporting them in developing strategies to manage these and maintain safe sleeping advice for their baby.

PSCP, in partnership, to consider working with the HIPS group to develop multi-agency guidance that provides consistent, evidence based messages; and role specific guidance on what we would expect different professionals to look for and then do. PSCP to also consider how these messages are built into the range of training across agencies, so that it is relevant and proportionate to their role and level of awareness needed around safe-sleeping messages.

Recommendation 5

Consider how PSCP supports the workforce to be clear that when discussing alcohol consumption with parents, as well as considering their weekly average, they discuss what happens on those occasional events when they may binge/drink much more than usual. This will help conversations around safe-sleeping in high-risk situations be more grounded in the family's real-life experience. Consider a drink free parent/carer in a similar way as they would consider a duty driver to prevent drink driving situations.

Portsmouth Hospitals NHS Trust

Recommendation 6

Portsmouth Hospitals Trust to undertake an audit of routine questioning about domestic abuse by midwives and put in place actions to ensure that this is embedded into practice. Audits should be repeated annually to ensure that practice has been embedded and progress maintained.

Recommendation 7

Portsmouth Hospitals Trust Maternity Services to review and improve their continuity of carer arrangements, especially when there is staff sickness, to ensure that women have at least some consistency of carer.

Recommendation 8

Portsmouth Hospitals to put processes in place to provide support for staff involved in serious incidents and case reviews. They should ensure that staff are informed promptly when a child they have been involved with has died and to ensure staff are appropriately prepared to participate in any learning events including access to the records.

Recommendation 9

Portsmouth Hospitals to have in place on the Children's Assessment Unit robust processes to check every child attending for unplanned care on CP-IS.

Solent NHS Trust

Recommendation 10

Solent NHS Trust to review their administrative process and put in place robust process so that new birth visits are not missed in the future.

Hampshire Police and Solent NHS Trust

Recommendation 11

As part of future arrangements for Joint Agency Response (JAR), where a child dies unexpectedly, the Chair of the JAR should ensure that all agencies have been identified and invited to contribute including maternity services and fertility clinics where appropriate.

A Fertility Clinic

Recommendation 12

The fertility clinic to explore the feasibility of either informing maternity services direct, or the GP, of a pregnancy where there is a background of unusual circumstances.

Recommendation 13

Fertility clinic to ensure that they have in place robust process for checking information provided by patients and their partners where there are unusual circumstances or when a child has died unexpectedly.