Serious Case Review Briefing

Child I

Case Summary

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 who had been drinking alcohol.

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.

Both parents had historically been known to the Police for alcohol related incidents however both claimed to have stopped drinking before becoming pregnant with Child I. They conceived Child I through fertility treatment.

Although Mrs I attended all of her ante-natal appointments, it was noted that she had seen five different midwives during this time. A Health Visitor discussed safe sleep with Mrs I and shared literature on this subject at the 38 week stage of pregnancy. Case notes also demonstrate that Mrs I was verbally and physically given further information on safe sleep on her departure from hospital, following the birth of Child I. Routine questions around domestic violence were not asked as the midwife was unable to speak to Mrs. I alone.

In May 2019, Child I's parents had a day out with friends. 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. Several hours later, Mr I found Child I still with Mrs I, who was asleep on the sofa. Child I was cold and lifeless. After attempted resuscitation and Child I being taken to hospital, Child I was tragically pronounced dead.

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.

Six months following Child I's death his parents attended a fertility clinic for frozen embryo transfer which was successful. 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.

The full report can be viewed here.

Learning Points

1. **Safe sleeping key messages.** Practitioners working with families should take every opportunity to remind parents of key safe sleeping messages tailored to their needs. There is specific advice which should be shared where parents do choose to co-sleep.
2. **Advice on supporting a bereaved family.** 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."
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. There are specific times when a re-assessment is required, such as a change in partners, the birth of a child, known changes to medical background. The centre should also obtain consent from the patient to share information with relevant professionals wherever possible.
4. **Routine enquiry in to domestic violence and abuse**. 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.
5. **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. **Five main functions of safeguarding supervision:** Clinical / reflective practice; Managerial; Developmental; Supportive; Advocacy. Click here for further information.
7. **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. For further information on this project, click here.
8. **Involvement of practitioners in review process**. 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.

Further details about these learning points can be found in the full report, here. The PSCP have also published a response document, outlining the actions that have or will be taken in response to the recommendations within this report. This document can be found here.

In July 2020, the National Panel published their report in to Sudden Unexpected Death in Infants (SUDI). Portsmouth were visited as part of the methodology for this review. Key learning from this report includes the strong link between alcohol and substance misuse and sudden infant death. It recommends that professionals tailor their safe sleeping key messages to the needs of the family's background and history. It also highlights the importance of planning for 'out of routine' events where a child's normal sleeping arrangements may be changed, especially when this involves alcohol. Portsmouth will consider the learning and recommendations from this report when forming an action plan from this case. For further information, please see this report.

Useful Resources

The Lullaby Trust (2020) Safer Sleep Advice.
NHS Choices (2019) Sudden Infant Death Syndrome- SIDS.
NHS Choices (2019) Pregnancy and Baby- Reducing the Risk of Cot Death.
Child Protection-Information System (CP-IS)
The lullaby Trust (2020) Supporting Bereaved Families
Out of Routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm