Key Learning: Annabel

Rapid Review

A rapid review is a statutory process which is required when a child has experienced a serious incident and it is known or suspected that they may have been abused or neglected. The purpose of the review is to identify any safeguarding concerns for them or other children in the family and any immediate learning that could improve future practice.

This rapid review was conducted in January 2024 following a serious incident notification being made in response to the death of a young baby. A Local Safeguarding Child Practice Review was considered; however, this was not progressed as the Rapid Response Panel were satisfied that learning was identified and taken from Rapid Review.

Safeguarding Concerns and Incident

Annabel was 10 days old when she tragically died, she lived with her mother, father, and older sister. She had a half-sister who lived outside the family home. Her family were open to universal services for support. Annabel's older sister had both been open to statutory services, previous issues included concerns around domestic abuse, neglect, and maternal mental health. Annabel had never been open to an assessment by children's services. Following her death and upon statutory services attending the property professionals highlighted concerns around the family living environment being unsanitary, cluttered, with evidence of prescribed medication being left on tables and evidence of cannabis being consumed by adults. Ahead of her death there had been a decline in mothers' attendance at appointments and engagement with services. Both children were sleeping in the same room as their parents and Annabel co-sleeping with parents.

The rapid review has considered the needs of the family and the support that they received in the antenatal and initial postnatal period by universal services.

Safer Sleep

Sudden Infant Death Syndrome (SIDS), which was formerly called 'cot death', is the sudden and unexplained death of a baby where no cause is found. Although SIDS is rare, it still accounts for a small but significant percentage of deaths among infants across the UK every year. Every one of these deaths is a tragic and unexpected loss for a family. Of the babies that died whilst sharing a bed with an adult, 90% died in hazardous co-sleeping arrangements. Although there is no clear cause or explanation for why SIDS happens, research has identified a simple set of key messages for parents and carers that may help reduce the risk of it happening to their baby. DSCP Pre Birth procedure

Annabel is an anonymous name

In the UK, around 200 babies dies suddenly and unexpectantly every year. Most deaths happen during the first 6 months. Parents can reduce the risk of SIDS by not smoking while pregnant or after the baby is born, and always placing the on their back (Sudden infant death syndrome (SIDS) - NHS (www.nhs.uk))

The Lullaby Trust guidelines state that there are key risks you should avoid if co-sleeping with a baby to reduce the risk of sudden infant death syndrome (SIDS) and that co-sleeping is dangerous if:

- You or anyone in the bed has recently drunk any alcohol.
- You or anyone in the bed smokes
- You or anyone in the bed has taken drugs or medication that makes you feel sleepy.

How to reduce the risk of SIDS for your baby - The Lullaby Trust

What's worked well

Safe Sleeping (SIDS): There is evidence within the record that safe sleeping was discussed with both parents at antenatal and new birth contact with Health Visiting, mother was signposted to the Lullaby Guidelines website. There is also documentation to identify that safe sleep was discussed out of the scoping period when mother was receiving care from the Family Nurse Partnership support.

Professional Curiosity: Early help was discussed with mother on three separate occasions by midwifery service.

When the parents were previously assessed by Children and Young People service there was evidence of a father and extended family being included in safety planning work.

Support: When mother was engaging with services there was a consistent discussion and referrals to services to help to assess and support her mental health.

The family had a consistent practitioner through the health visiting service.

Appointments There were TAF's in place throughout involvement from 2015–2020. These included relevant professionals including Health Visitors, Midwife and Mums support worker. Case file indicates agencies communicating throughout episodes.

Learning from Practice

Safe Sleeping (SIDS): Safer sleeping advice needs to be robust and bespoke for families where there are additional vulnerabilities. It needs to consider in detail the increased risks in each case and involve the multiagency professionals working with the child and family.

Professional Curiosity: Professionals working with a family should fully understand the parental history held across agencies, including a full understanding of any mental health difficulties, care experienced parents and drug/ alcohol difficulties. The parents' history should also include any other children they have parented and consideration to children both in and outside their care.

Fathers should not be missed or an after-thought, at all meeting fathers need to be considered as a potential risk or protective factor to a child. Men can play a vital role in their children's development and wellbeing and have a major influence on the children they care for. However, often male caregivers go 'unseen' by services involved with children due to:

- A lack of professional engagement and curiosity
- An over-focus on the quality of the care that children receive from their mothers.
- Inadequate information sharing between services. All professionals have a responsibility to engage with fathers or question any apparent lack of engagement from other agencies. This includes putting key information in writing.

Missed Opportunities for support: Any change of circumstances or sharing of concerns must consider, first and foremost, the impact on the child. Professionals need to balance supporting a vulnerable parent with clear child focused challenge about the potential for a negative impact on the child.

Missed Appointments: Professionals need to ensure that having a previous positive relationship with family members does not lead them to lose focus or be over optimistic about the potential for harm to a child when a parent is not engaging in appointments or being open and honest.

Sharing of information and collaboration of professionals: There are several missed opportunities for agencies to share information which would have been useful in building a picture of what was happening with the family, and this was not limited to one agency.

What is the DSCP doing?

The DSCP will continue to communicate with all partners the key messages in relation to safe sleeping and sharing this information wider.

DSCP are supporting the eyes on the baby training and this training will be made available to all partners within Durham.

The DSCP are developing a Tier 1 information sharing agreement, this will strengthen the understanding for partners to speak to one another and address any barriers that might be in place. All partners are being asked to review their processes around missed appointments. CDDFT and HDFT are to revise their process around the escalation of missed appointment.

Father inclusive practice continues to be a DSCP golden thread, work will continue to be completed across the partnership looking at how to promote good practice.

How we practice in Durham procedure to be updated t make it clear that safety plans should be shared when cases are closing to practitioners and CYPS

All agencies to review safeguarding supervision procedures, to support a clear line of sigh within their own agency.

What can you do? Any professional coming into contact with families with young babies can make a difference by having conversations about safer sleep. Health professionals are key, but others including housing, social care and emergency services can make a difference by using the Safer Sleep Guide to identify the risks and promote adopting safer sleep methods to parents and carers.

Discuss this key learning briefing in team meetings and in supervision.

Local Resources

- Culminative Harm guidance Practitioners Quick Guide to Cumulative Harm (durham-scp.org.uk)
- ICON Training http://iconcope.org/
- SIDS Training SUDI eyes on the baby training
- NSPCC Learning *'Unseen men: learning from case reviews'* (September 2022) Unseen men: learning from case reviews | NSPCC Learning
- The Home Environment Assessment Tool, HEAT 'Toolkits and guidance for practitioners: HEAT Toolkit
- Child Safeguarding Practice Review Panel 2020 Out of routine: A review of sudden unexpected death in infancy (SUDI),
- DSCP Learning from Father inclusive practice
- DSCP Clarify, Verify and Reflect: Professional Curiosity
- Safeguarding children at risk from sudden unexpected infant death Safeguarding children at risk from sudden unexpected infant death - GOV.UK (www.gov.uk)