One minute guide

Learning from a Blackpool Serious Case Review

June 2020

Overview

In March 2019, a 10-week-old baby died. The cause of death was overlay (when another person shares the sleep surface with the infant and lays on or rolls on top of or against the infant while sleeping, blocking the infant's airway).

During the booking appointment with the midwife, the mother was asked routine questions around domestic abuse, lifestyle and support needs with the mother agreeing to a referral to receive support to stop smoking. GP records indicate that the mother had a short history of some pre-disposing risk factors that are known to impact on parenting capacity, these factors however do not appear to have been present as issues during the review period.

During the pregnancy, the child's paternal uncle moved into the household. This adult has a conviction for a serious crime (not related to children) and was subject to monitoring arrangements by the National Probation Service.

No concerns were noted during further appointments or scans including standard enquiries about domestic abuse or other issues.

Child CE was born without complications and mother and baby were discharged home the following day. Further appointments were carried out with no indications of concerns and Child CE was making good progress.

An ambulance attended the home address having been called by a male because Child CE was not breathing. The ambulance crew noted that the mother had been out and returned home to find Child CE sharing a bed with the father. Child CE was taken to hospital and sadly pronounced dead

Based on regular interactions between the mother and relevant professionals during the pregnancy, and Child CE's first weeks of life, no concerns were observed or identified about the mother or father's care. Throughout this time there had also been no concerns about the care, safety or welfare of Child CE's half-sibling.

Positive parenting was noted.

Learning Points

- It is important that all professionals understand, and follow, agreed policy and procedures. Failure to do so may place a child or vulnerable adult at risk.

- Midwives and Health Visitors are uniquely placed to identify early signs of information that might be of interest from a safeguarding perspective. Being actively curious about members of the household, family dynamics and actual, or potential, risks to children is an important consideration for practitioners. Contemporaneous record keeping is an essential requirement following all appointments and contacts.

- Fathers care for babies too. Ensuring fathers are given the same advice and support as mothers is important. When meeting expectant and new mothers, reflect on whether you are making assumptions about the role of the father in the household. It is also important to extend this advice to other significant adults who may care for a baby i.e. grandparents.

- Ensuring new parents think about safer sleeping arrangements for the baby is a core task for all professionals. Asking questions in order to encourage discussion about sleeping arrangements will help parents reflect on safer sleeping arrangements.

- Ensuring good record keeping and the central collation of records within an agency is an important and core task for all professionals. Records should be clear, accurate and completed in a timely manner. They provide a record of your work, the work you do on behalf of the agency you work for, and a record for the next worker should you decide to leave your post or be away from work. Aside from the accountability elements of recording, recording allows information to be collated and analysed should an escalation of intervention be needed.

Read the full report

Key Contacts and Further Information

Coventry Safeguarding Children Partnership website