Local Learning Review for Baby Sally

Overview of Baby Sally's Case

On 6 February 2019, Sally's mother had a telephone consultation with the General Practitioner (GP), which suggested that she was likely three weeks pregnant. Evidence suggests that several agencies from health and social care were aware of Sally's mother in Surrey and Hampshire. She was known to Adult Mental Health Services and on multiple medications. Her social care history indicated that her two older children were under the care of Surrey Children's Services.

On 25 and 27 February 2019, there were two anonymous calls to Children's Services alleging that Sally's mother was pregnant and consuming a high level of alcohol and misusing substances. She attended the Emergency Department (ED) on both occasions with abdominal pain and query ectopic pregnancy. During the month of February 2019 records show several hospital visits, GP contacts, referrals to social care regarding concerns for the unborn baby and midwifery highlighted some "did not attend" appointments. There was also some confusion in February 2019 regarding her pregnancy status.

On 4 March 2019, Sally's mother had a telephone consultation with the GP informing him that she had booked a pregnancy termination and was requesting some sleeping medication as she was anxious. The GP shared this information with the Health Visiting Team at the time. This request triggered concerns about Sally's mother's drug dependency. The pregnancy termination discussion was very evident during the month of March, with frontline staff not sure of her pregnancy status. On 12 March 2019, mother had a further telephone consultation with the GP where she indicated that she was having second thoughts about having a pregnancy termination.

On 25 April 2019, the GP received a call from BPAS (British Pregnancy Advisory Service) informing them that Sally's mother was still pregnant. This was due to a failed termination of pregnancy. The GP informed the midwife on the same day and provided help regarding housing and accessing 'SureStart'. In addition, on the same day, the midwife sent a referral to Children's Services due to the mother and father's social history as care leavers.

On 26 April 2019, Sally's mother booked in for antenatal care. This was a late booking for antenatal care as she was already 15 weeks pregnant. The hospital records show several attendances at the Emergency Department (ED) during the pregnancy. Sally's mother had support from the midwife, community midwife, Perinatal Mental Health Team and had consultant-led antenatal care. This meant she had a consultant obstetrician responsible for her care.

On 30 April 2019, Sally's mother confirmed that she was going to continue with the pregnancy and Children's Services commenced a Child and Family Assessment. Despite numerous attempts at visiting Sally's mother to undertake this assessment, these were not successful. Throughout May and early June 2019, Sally's mother engaged with some health services but only regarding her own health, she failed to attend the majority of appointments related to her pregnancy.

The Multi Agency Safeguarding Hub (MASH) was also contacted by Sally's father on 30 April 2019 who informed Children's Services that mother had told him he was the father of Sally. He also confirmed he was a care leaver.

On 4 June 2019, Children's Services initiated a Section 47 investigation following a referral from the hospital midwife due to mother's complex issues, substance misuse and mental health. Whilst the responses to the previous referrals were viewed as appropriate, it was evidently time to escalate the case due to the lack of engagement by Sally's mother. The investigation concluded in a Child Protection Conference on 26 June 2019 and Sally (unborn) became subject to a Child Protection Plan (CPP). Records show that Sally remained on the Child Protection Plan as an unborn baby and following her birth. There was an agreement with hospital staff not to discharge Sally from the hospital to the care of her mother.

On 16 July 2019, Children's Services held a Legal Strategy Meeting (LSM) to consider Public Law Outline (PLO) or an application to the court for a Care Order for Sally. A set of actions were agreed including completing the pre-birth assessment, but Children's Services did not issue PLO or initiate proceedings. A second Review LSM was held on 3 September 2019, following completion of the pre-birth assessment, and the decision to issue proceedings was made (to happen immediately following the birth of Sally as it is not possible to issue on an unborn child).

On 8 October 2019, Sally's mother presented at the hospital in labour. After she gave birth, Children's Services were notified (Out of Hours) by the midwife. The hospital also noted some negative behaviours by Sally's mother during her stay in hospital; this included non-compliance with some care plans for the baby and her smoking habit continued.

On 10 October 2019, Sally's mother was noted to have Sally in bed with her whilst still in hospital, it is recorded that this was noted on two further occasions as well. The records show that "Safe Sleep" messages were given to the mother of Sally whilst she was in hospital and upon discharge from hospital. Unfortunately, on one occasion, it is also recorded that mother was permitted to keep Sally in bed with her as it was deemed the only way to settle the baby down. Whilst it is understood that Sally was proving very difficult to settle, it does mean that her mother received some conflicting messages.

There is some evidence to suggest that Sally's mother was often contradictory about her own medication. At times she appeared to want to reduce the amount she was taking and at others, that she did not. However, there is evidence that the GP monitored the prescription of her medication and made significant efforts to engage with medical colleagues to address concerns about the impact of her medication on her parenting capacity.

On 11 October 2019, Children's Services' application to the court for a Care Order was heard at an initial hearing and an Interim Care Order (ICO) was granted with a plan for a mother and baby placement to assess mother's parenting ability safely whilst not separating mother and child.

On 14 October 2019, the discharge planning meeting was held, and Sally's mother was informed of the placement. It is very clear that "Safe Sleep" messages were given to Sally's mother during her hospital stay and that she was provided with leaflets and guidance around this issue. There is some disagreement about whether this was specifically discussed in the discharge planning meeting. The hospital are confident this was discussed; Children's Services have no record of it being discussed. (Whilst this review is unable to resolve this conflict, it is immaterial to the valuable learning that arises from it.)

To make use of the mother and baby placement, Sally's mother had to sign up to a working agreement regarding what the arrangements were and what the expectations were upon both her and the foster carer. Due to the level of medication mother was taking, her continued smoking and the risk of her returning to drugs and/or alcohol, this included Sally sleeping in the foster carer's room during the night. Sally's mother was very reluctant to sign this agreement and was unhappy that she could not take Sally home.

On 16 October 2019, the foster carer alerted the community midwife that she was concerned about mother's behaviour. The community midwife shared the information with the GP and the social worker. This is an example of good communication. On 17 October 2019, the GP called the midwife as they were concerned that the mother had "kicked off" and about the impact of her medication on her parenting capacity.

On 18 October 2019, the GP had a conversation with the psychiatrist about their concerns regarding the discharge from the Perinatal Mental Health Service. On 22 October 2019, the GP sent a detailed letter of referral to the Perinatal Mental Health Team. The referral was not accepted as they said it did not meet their criteria. The GP was concerned about mother's capacity to parent in relation to the drugs she was taking and made the decision to discuss her repeat prescription with the Mental Health Service before prescribing more. The discussion with the psychiatrist resulted in a weekly prescription.

On 21 October 2019, both mother and the foster carer requested that Sally start sleeping in mother's room as the current arrangement was unfair to Sally's mother and the foster carer was not getting sufficient sleep due to Sally having disturbed sleep. This was raised again at the Core Group Meeting on 25 October 2019. Both times the decision was to maintain the status quo until the court hearing on 28 October 2019 when a decision could be made with all parties.

On 21 October 2019, the same day as the placement meeting, the health visitor gave the safe sleep advice during the new birth visit at the home of the foster mother. The foster mother was present for half the duration of the new birth visit. Advice on smoking cessation and having a smoke free home was given to Sally's mother by the health visitor as it was noted that she is a smoker. It is not clear if the health visitor was aware of the foster mother's struggle with the sleeping arrangement or if the foster mother was present for the safe sleep discussion. It is also not clear if the health visitor checked the sleeping environment in the foster carer's room or what the potential arrangements would be if Sally began sleeping in mother's room.

On 28 October 2019, the decision to allow Sally to sleep in mother's room was made at the hearing (outside of the court, not with the participation of the Judge), where all parties' legal representatives were present. There is no record to indicate that mother's history of co-sleeping with Sally in hospital was factored into that decision making. It is notable that there were no colleagues from health services present to inform that decision either. It is also noted that health information was not requested for this hearing.

On 30 October 2019, Sally's mother called 999 stating Sally was in cardiac arrest. Sally's mother woke up at 7am to find Sally was not breathing. Sally's mother had taken Sally into her bed at 4am. Sally was conveyed to the hospital by ambulance and was pronounced dead shortly after arrival.

Findings and Analysis

1. **Discharge Planning**

There is a disagreement between the hospital and Children's Services about whether mother's recent history of co-sleeping was discussed at the discharge planning meeting and if the safe sleep information was provided in the context of a known risk or simply "business as usual". The records of the meeting do not record such discussions. Regardless of whether information was shared or not, enquiries made by the review team suggest that the process of calling, running, and recording discharge planning meetings is unclear and variable in practice.

Recommendation 1: Hampshire Safeguarding Children Partnership (HSCP) to develop a policy that clearly articulates the key principles and rationale for discharge planning meetings where there are safeguarding concerns (as opposed to planning for broader health needs) and what roles and responsibilities there are for different agencies. This policy will clarify what safeguarding concerns would require a discharge planning meeting (being discharged to a placement being sufficient to warrant one) and define attendance, agenda setting and recording practices. This should be shared across the HIPS network.

2. Information Regarding Safe Sleeping Practices

Safe sleep information and messages were given to Sally's mother repeatedly by professionals during her stay in hospital and following discharge. Hospital staff also intervened when mother was found to have Sally in bed with her and informed her about the risks of co-sleeping. However, it would appear that on one occasion, mother was allowed to keep Sally in bed with her due to the disruption caused by the attempts to separate them.

Recommendation 2: That all professionals (including foster carers) are reminded of the importance of adhering to safe sleep protocols, regardless of the attraction of taking a more pragmatic approach due to the circumstances at the time. Consistency between the messages given by and role modelling provided by professionals, is vital to ensuring parents receive a single clear message about the risks of co-sleeping.

As discussed above, information sharing in discharge planning meetings is crucial to ensure all professionals are fully apprised of the risks present in a case prior to discharge. However, this should not be relied upon as the single point of information exchange between professionals. The more professionals check and confirm with each other what the risks are in a case, the more confidence we can have in our risk management plans. In this case, regardless of what was, or was not discussed in the discharge planning meeting, the foster carer was not present. She was also not present for the full first visit of the health visitor to the placement. In fact, there is no record of her being present when it was discussed or of her being informed of the history of mother co-sleeping with Sally in hospital and given her role, this is a significant gap in her awareness.

Recommendation 3: Where parents and their new babies are discharged to placements, the carers and/or staff must be fully informed of all the risks present in the case and ought to be integral to the discharge planning meeting. If they are unable to attend, then professionals must ensure all information is effectively shared with them and this must feature in the actions resulting from the discharge planning meeting.

Following discharge from hospital, a variety of professionals visited mother and Sally in placement. Whilst safe sleep advice appears to have been given consistently, it is not clear if this was provided within the context of mother's history of co-sleeping with Sally in hospital or simply as general advice. There is also scant evidence of the sleeping arrangements being looked at to locate the advice being given to the individual circumstances of Sally.

Recommendation 4: That home visiting protocols are reviewed for all professionals following the discharge of an infant from hospital, to highlight that best practice when delivering safe sleep advice is to do so whilst considering the sleeping arrangements for the child. This can be reflected within the proposed discharge planning policy.

Sally and her mother were discharged from hospital to a social care mother and baby foster care placement in Hampshire. There may be a lack of understanding from partner agencies about the legal framework that applies to children placed on Care Orders and who has parental responsibility when a child is subject to a Care Order and in a mother and baby placement. The removal of the child from a Child Protection Plan in such circumstances must not be seen as a reflection that the level of risk has reduced. It is a reflection that the Care Order and Care Plan negate the need for a Child Protection Plan.

Recommendation 5: HSCP and partner agencies should ensure that relevant child protection training includes the understanding that Child Protection Plans are often removed from children when they become subject to Care Orders and that this does not necessarily indicate a reduction in risk but may reflect a different mechanism for managing that risk.

The decision to allow Sally to sleep in her mother's room was made at the hearing on 28 October 2019 (outside of the court, not with the participation of the Judge) where all parties' legal representatives were present. There is no record to indicate that mother's history of co-sleeping with Sally in hospital was factored into that decision making. It is notable that there were no colleagues from health services present to inform that decision either.

Recommendation 6: Whilst it is recognised that some decisions about care planning are made without notice, such as during court proceedings, where it is known a decision may be made in advance, every effort should be taken to seek the views of the multi-agency team to help inform that decision making.

3. Medication

The issue of Sally's mother's medication and the impact it may have had following birth on her ability to parent effectively, regulate her emotions and remain focussed enough on Sally does not appear to be concluded effectively in the records. Whilst it may well have been assessed to the satisfaction of one or more clinicians, there remained evidence of some confusion for other professionals and mother herself, though it might be she deliberately contributed to that confusion given her conflicting and variable demands for both an increase and a decrease in dosage at different times.

Recommendation 7: Where there are concerns about the impact of medication on mothers (or parents) before or after birth, the assessments and conclusions of clinicians reviewing medication should be provided in writing and shared with all relevant professionals to support effective care planning and risk management.

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