7 Recommendations

- Ensure babies discharged from Neonatal Units are receiving timely and appropriate assessment and support post discharge.
- Ensure practitioners working with babies with complex needs are aware of the impact on the family.
- Review the current safe sleeping advice to include the impact of alcohol consumption and smoking when caring for a young baby; and communicate this effectively to families.

6 Supporting Parents

Already having a child does not mean that parents are automatically able to care for a poorly baby. The review suggests that practitioners should note the impact of having a poorly child on a family and consider the use of Early Help Services/ Assessments as a means of supporting families who present with a child who has complex health care needs, taking into consideration other risk factors such as mental health, domestic abuse or histories of vulnerability.

5 Information Sharing and Discharge Planning

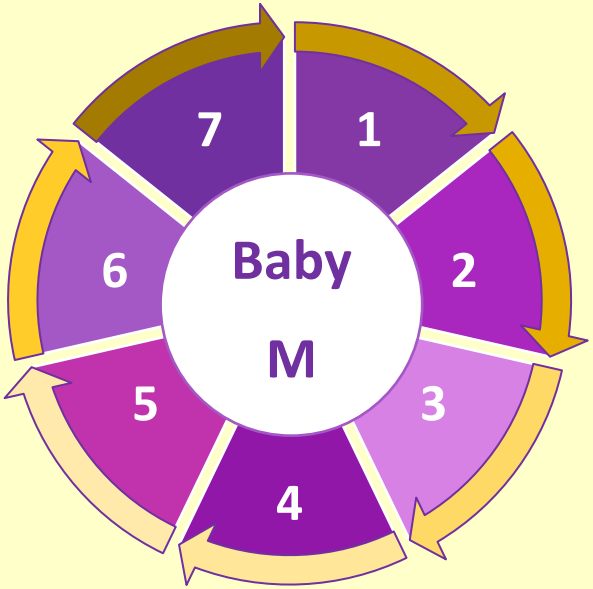
This review highlighted that effective information sharing about a family's context on admission as well as discharge planning that includes key frontline health practitioners from the child's local area is vital in providing good quality care and support to babies who have additional complex care requirements. It informs an understanding of risk. In this case it could have allowed for consideration of the family's history, together with current circumstances, strengths, risks and concerns to be fully explored and considered. The neonatal units involved have reviewed their discharge procedures to ensure learning from this review is embedded.

To read the full Serious Case Review:

http://www.safeguardingchildreninstockport.org.uk/wp-content/uploads/2019/11/Serious-case-review-Baby-M.pdf

1 How did we review?

Conducted by an independent reviewer in line with statutory requirements. The focus was on Baby M's lived experience and is intended to provide learning to improve services.



4 Alcohol and Safe Sleep

Learning from this review about alcohol and co-sleeping reminds us of the importance of providing safe sleep guidance at every contact, highlighting the increased risks associated with drinking, smoking and substance misuse.
A 7 minute briefing on safe sleep can be found here:
http://www.safeguardingchildreninstockport.org.uk/wp-content/uploads/2019/10/Safe-Sleep-for-Babies.pdf

2 Background

Baby M was a well-loved child with an infectious giggle and a smiley happy face. He lived with his mother and his 5 year old maternal half-brother (Child C). His parents had an on/off relationship and his father did not reside at the family home. Domestic Abuse had been reported on one occasion.

His mother had a history of vulnerability and adverse childhood experiences. Neglect was reported with Child C in 2014, and Early Help interventions were put in place. No agency had concerns about the parenting of Baby M, who was born in March 2017.

Baby M's 20 week scan showed an absent right kidney. At birth he had extensive complex health needs and required intensive medical treatment at a specialist centre. After 12 weeks he was discharged home where an Enhanced Health Visiting Service provided additional support. Post discharge he was admitted to hospital 4 times, 3 due to his health needs and 1 due to an accidental vitamin overdose.

3 Incident

Baby M was found lifeless by his mother in October 2017. Paramedics and Police Officers attending that morning were concerned she presented as intoxicated and provided apparently contradictory accounts of the previous evening's events. Toxicology reports showed she had been drinking but was not as intoxicated as her presentation may have suggested. She was arrested on suspicion of child neglect, as there were concerns of death by overlay when sharing a bed the previous evening. The case was subsequently closed due to lack of evidence. Baby M's brother Child C was staying at his father's house, so was not present. Following Baby M's death, Child C was to stay in the care of his father.

7 Minute Briefing