Lessons Learned

Warwickshire Safeguarding

Noah's Story....

Noah was born prematurely (under 30 weeks) and prior to his birth he was subject to a Child Protection Plan due to concerns over domestic abuse and substance misuse between his parents. When Noah was able to leave hospital, he went to live with his mother at his grandparents' house.

Noah's parents remained in a relationship and Noah's father participated in domestic abuse perpetrator work and sought support for depression from mental health services. Noah's mother sought support for her alcohol abuse, however the parent's engagement with these services and programmes fluctuated.

When Noah was a little over 3 months old, he became unwell with cold like symptoms. Noah's mother took him to the GP and she was given advice to manage Noah's symptoms. That night Noah's mother bathed and put him to bed as normal and Noah's symptoms appeared to improve. Noah woke shortly before midnight so to settle him, Noah's mother brought him into her bed and they both went back to sleep.

Noah's mother woke early the following morning and realised that Noah hadn't woken up for his feed. When Noah's mother checked him, she found he was unresponsive with vomit on the bed next to him. Noah's grandparents called an ambulance and Noah was taken to the local hospital where he was sadly pronounced dead.

What we have learned....

Noah's mother had some ongoing health complications following Noah's birth. Noah's mother failed to attend her post-natal check up with the GP and therefore was unable to access treatment or support from services. This was considered a missed opportunity for the GP to check in with Noah's mother and gain an understanding of her health, support needs and Noah's welfare whilst he was subject to a Child Protection Plan.
Learning for Practice: *When mothers of children subject to Child Protection Plans miss post-natal check-ups, the GP should take a proactive approach and make a follow up telephone call to ascertain mums health and wellbeing as well as that of the child alongside the new appointment that is generated automatically by the surgery and sent by letter.*

The GP was not invited to Noah's Child Protection Conferences which left them without a full picture of Noah, his family and any concerns raised by professionals.
Learning for Practice*: Although it is recognised that GP's can often not attend Child Protection Conferences due to clinics and capacity, they should always be invited to attend or send a suitable representative from the surgery or submit a written report in order to share/gain relevant information on children and their families. Minutes from these meetings should also be sent to the GP, even if they are not in attendance.*

Both Noah's mother and father were accessing services for either substance misuse or domestic abuse. Both parents were hard to engage in these programmes and their engagement started to decline.
Learning for Practice: *Where programmes are put in place for parents whose children are subject to Child Protection Plans and their engagement starts to wane, practitioners need to be careful to avoid over optimism of the parental capacity to change and not be afraid to take the next steps should progress stall.*

Lessons Learned (cont.)

Warwickshire Safeguarding

What we have learned (contd.)....

Noah's mother informed her Social Worker that she no longer felt the need to access support for her substance misuse and wished to end her engagement. The Social Worker fed this back to mum's Substance Misuse Practitioner who closed her case.
Learning for Practice: *If a client is wishing to end their involvement with a Substance Misuse Service and this information is relayed by another practitioner working with the client, then the Substance Misuse Practitioner should follow this up seek confirmation from the client to ensure that any issues/concerns can be addressed.*

Although a post-mortem could not ascertain the cause of Noah's death and no single person was responsible, it is important to recognise that there were indicators that Noah was at an increased risk of Sudden Infant Death Syndrome (SIDS). Noah was born prematurely, he was under 6 months old when he died, he lived in a household where adults smoked cigarettes, his father smoked cannabis, his mother was known to drink alcohol and on various occasions when he could not settle, Noah's mother would co-sleep with him.
Learning for Practice: *SIDS and Safer Sleep for babies and infants is often a conversation that practitioners working with families in other agencies assume that Health Visitors or Early Years Practitioners are having with parents. To reduce SIDS it is the responsibility of all practitioners who work with babies, parents and others within the household (i.e. grandparents) to be aware of where the risk of SIDS may increase and have conversations with mothers, fathers (don't forget dad!), carers and grandparents about safer sleep for babies and infants.*

What do I need to do...

Advice for professionals

1. Visit Warwickshire Safeguarding Partnership's *website* for more information and resources on Safer Sleep for Babies and Infants, including the *Safer Sleep Guide for Practitioners* and 7 Minute Briefing on *Co-sleeping and Safer Sleep for Babies and Infants*.
2. For further information on Child Protection Conferences, visit the West Midlands Regional Child Protection Procedures -1.10 Child protection conferences.

Advice for communities

1. Safer Sleep for babies and infants and is something **all** family members should be aware of. Visit the Lullaby Trust for a range of information on safer sleep and what can be done to reduce the risks of SIDS.