# Barnsley Safeguarding Children Partnership

# Local Child Safeguarding Practice Review – Child W


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## 1.0 Introduction

**1.1** During May 2020, two days old child W sustained injuries from which she subsequently died after apparently being overlaid by her mother who appears to have fallen asleep whilst caring for the child. At the time of the incident mother and child W were receiving postnatal care in hospital. It had been necessary for child W to remain in hospital for 3-5 days following birth to enable monitoring of withdrawal symptoms, given mother's long term use of prescribed morphine.

**1.2** Antenatally, children's social care had decided to remove child W from the care of her parents at birth. All mother and father's previous children had been removed from their care and they had made determined efforts to conceal the birth of a previous child from the authorities. Children's social care had applied for an Interim Care Order which was granted on the first working day after the incident in which child W was severely injured.

**1.3** Barnsley Safeguarding Children Partnership decided to conduct a Local Child Safeguarding Practice Review (LCSPR). David Mellor was appointed as the independent reviewer. He is a retired police chief officer who has nine years' experience as an independent reviewer of LCSPRs have and other statutory reviews. He has no connection to services in Barnsley. A description of the process by which the review was conducted is set out in Appendix A.

**1.4** An inquest into the death of child W may be held in due course.

**1.5** Barnsley Safeguarding Children Partnership wishes to express sincere condolences to child W's family.

## 2.0 Terms of Reference

**2.1** The period on which this review has primarily focussed is from October 2019 when agencies became aware of mother's pregnancy with child W, until 16th May 2020 when the new born child W suffered injuries which later ended her life. There are a number of significant events which took place prior to October 2019 which have also been considered.

**2.2** The key lines of enquiry addressed by the review are as follows:

- How effective were the actions taken to safeguard child W following her birth?
- How comprehensive was the assessment of mother, father and the unborn child W?
- How effective was the Child Protection Plan for child W?
- How effective was the Birth Plan for child W? Did the Birth Plan address any interval between birth and the removal of the child from her parents?
- Did the earlier than anticipated delivery of child W impact upon the implementation of the Birth Plan in any way?
- Given that Care Proceedings could not be heard until 4 days after the birth of child W at the earliest, should more urgent action to remove child W have been considered?

- How effectively were any risks mother may present to child W assessed and managed, including the risks associated with co-sleeping?

- Was safe sleeping advice given to mother?

- How effective was the supervision of mother and child W on the postnatal ward, including:
- 'specialing' (enhanced observation of a patient)
- how health care workers perceive risk and act on this
- the risk assessment documentation
- the handover between shifts
- the role and input of the BHNFT safeguarding team

- Was the prescribing of oral morphine to mother by her GP in accordance with expected policy and practice?

- Was the dispensing of oral morphine to mother by the hospital pharmacy in accordance with expected hospital policy and practice? Should there have been any communication between the hospital pharmacy, the postnatal ward and the GP?

- How effectively were any risks father presented to child W, directly or indirectly, managed? Did the fact that Covid-19 restrictions largely precluded his presence in hospital affect practitioner's appreciation of the risks he may present to child W?

- Did practitioners consider the possibility that father could exercise coercive control over mother by telephone or other means?

- Did restrictions imposed as a result of Covid-19 impact in any way on measures necessary to safeguard child W?

- Is the learning from this LSCPR consistent with the learning from the National Panel Review of Sudden Unexpected Death in Infancy?

### 3.0 Glossary

**Domestic violence and abuse** is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, psychological, physical, sexual, financial and emotional abuse.

**Emergency Protection Order** is an order which enables a child to be removed from where they are, or be kept where they are, if this is necessary to provide immediate short term protection. An application for an EPO is regarded as a very serious step, and the Court to which the Local Authority applies must be satisfied that it is necessary and proportionate and there is no more appropriate order which could be sought.

**Interim Care Order** is an order made by the Family Court under which a child can be looked after by the Local Authority on a temporary basis until the Court can make a final decision about the future of the child.

**SafeLives DASH** (Domestic Abuse, Stalking and 'Honour'-based violence) is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to the Multi-Agency Risk Assessment Conference (MARAC) and what other support might be required.

**Section 47 Enquiry** is required when children's social care have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm. The enquiry will involve an assessment of the child's needs and the ability of those caring for the child to meet them. The aim is to decide whether any action should be taken to safeguard the child.

A **Strategy Discussion** must be held whenever there is reasonable cause to suspect that a child has suffered or is likely to suffer significant harm. The purpose of the Strategy Discussion is to decide whether a Section 47 Enquiry under the Children Act 1989 is required and if so, to develop a plan of action for the Section 47 Enquiry.

## 4.0 Synopsis

**4.1** Mother and father are well known to services and first came to notice in Barnsley in 2013 when midwifery services noted that mother, who was pregnant, and father were the subject of a National Alert instigated by Durham children's social care having left that area without notice. On that occasion the new born baby was removed into care at two days of age and subsequently adopted.

**4.2** Both parents have a number of previous children, none of which are in their care. Mother has given birth to five previous children, all taken into care, and father is reported to have fathered eleven children, none of whom are in his care.

**4.3** Locally, there was a history of domestic abuse in father and mother's relationship. The first reported incident took place in October 2013 when father punched mother following a verbal argument. Father was charged and later convicted of assault. The sentence included a 'programme requirement', the details of which are not known. Over the following years the police were called to seven verbal arguments between mother and father. The arguments often related to the large number of dogs they kept on the premises and financial issues. In September 2017 mother disclosed that father had punched her on the torso but declined to answer the DASH (Domestic Abuse, Stalking and 'Honour' Based Violence) risk assessment questions nor would she support a prosecution.

**4.4** On 6th April 2019 the police were called to an incident of domestic abuse involving father and mother which was assessed as 'medium' risk. Father was arrested for common assault although the Crown Prosecution Service (CPS) decided to take no further action. Mother's responses to the DASH questions indicated longstanding coercive and controlling behaviour by father. A 'helpline referral' was agreed. Mother was noted to be five weeks pregnant at the time. It is not known what the outcome of this pregnancy was. (GP records indicate that mother had 9 pregnancies, 5 of which led to live births) There is no indication that the pregnancy generated any concern in the light of mother and father's prior history (Paragraph 4.1)

**4.5** A further domestic abuse incident was reported to the police on 19th May 2019. This was a verbal dispute between mother and father which was assessed as a 'standard' risk. Mother declined domestic abuse support and father was said to be returning to live with his

parents in Durham. There is no reference to mother being pregnant at the time of this incident.

**4.6** On 3rd October 2019 mother was discharged from the specialist epilepsy service – provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) - following a consultation with a neurologist during which dosages and titration of her epilepsy medication were explained.

**4.7** On 13th November 2019 mother telephoned the specialist epilepsy service to say that she had not had any epilepsy medication for the past ten weeks and that her seizures had increased. She also said that she had recently changed her GP practice. The specialist epilepsy team contacted mother's GP practice which advised that she had declined appointments in respect of her medication but that prescriptions had been issued for some epileptic medications and sent to her pharmacy.

**4.8** The following day (14th November 2019) the specialist epilepsy service had further telephone contact with mother. The service checked mother's electronic record and noted that on 30th October 2019 the GP Out of Hours service documented that mother was pregnant after taking a home pregnancy test two days previously. (This initial notification of mother's pregnancy is recorded only in the SWYPFT chronology submitted to this CSPR). The epilepsy specialist discussed mother's pregnancy with her because some anti-epilepsy medications are contra-indicated in pregnancy. Mother said that she had become pregnant after her implant failed and that, at her request, her GP had arranged an appointment on 20th November 2019 for termination of the pregnancy. Later the same day the epilepsy specialist spoke to mother's GP practice to discuss her epilepsy medication. The GP said that mother had been advised to self-refer to a British Pregnancy Advisory Service (BPAS) clinic for a termination two weeks previously but mother did not appear to have done this.

**4.9** The consultant neurologist subsequently advised mother's GP that her epilepsy medication could continue if the termination was taking place. Mother was invited to an appointment with the specialist epilepsy service on 13th December 2019 to discuss her medication and establish whether or not she was still pregnant.

**4.10** On 26th November 2019 mother phoned the specialist epilepsy service to say that her GP practice would not issue any medication to her because her patient records from the previous GP practice had not been transferred. She confirmed that she was going ahead with her termination although she had no date for this as yet. The epilepsy specialist contacted mother's GP practice which advised that mother, accompanied by father, had visited the surgery that day to request 'pain medication' which the GP had been reluctant to prescribe as mother had already been prescribed 'two lots of painkillers' that week. The GP added that mother had not requested epilepsy medication which the practice was reluctant to prescribe due to her pregnancy. The GP was asked to check whether the letter from the consultant neurologist (see previous paragraph) had been received. The GP said that 'an alert had been utilised' during the consultation with mother and father as the GP had felt threatened. The GP documented that during the consultation mother had started crying and father had entered the room at some point and begun 'speaking loudly'.

**4.11** On 5th December 2019 mother contacted the specialist epilepsy service wishing to re-start her epilepsy medication as she reported having more seizures. She said that she had a dating scan arranged for 11th December 2019 and the termination – in Newcastle - was also booked in. The epilepsy service phoned mother's GP practice which said that they were confident that the termination was going ahead and, as such, they were happy to

recommence mother's epilepsy medication. Mother later confirmed that she had re-started her epilepsy medication and had had no further seizures.

**4.12** On 2nd January 2020 the epilepsy team phoned mother who said that because she had been depressed she had not attended the scan appointment and the termination had not yet taken place. Mother said that she was still planning to have a termination and was advised to continue with the epilepsy medication. It was planned to review the situation the following week but several calls to mother's mobile phone between 8th and 17th January 2020 received no reply.

**4.13** On 17th January 2020 the epilepsy team phoned mother's GP practice which said that mother had not been seen by them since 5th December 2019. The GP practice had been contacted by BPAS on 19th December 2019 to advise that mother had not attended for the scheduled scan. The GP practice went on to advise that mother had previously had five children removed from her care and adopted for 'safeguarding reasons', although mother was said to be hopeful that she could keep the baby from the current pregnancy.

**4.14** The epilepsy team offered mother an appointment for 27th January 2020 which she did not attend.

**4.15** On 12th February 2020 BPAS Safeguarding Admin contacted children's social care to advise that mother was around twenty four weeks pregnant with an estimated delivery date (EDD) of 1st June 2020. BPAS added that mother had initially attended the service in November 2019 stating she wanted to have a termination but had not attended further appointments and the service had been unable to contact her for some time. It was understood that mother had arranged her own scan after missing a BPAS scan appointment. BPAS went on to say that mother had re-contacted them on 8th February 2020, at which time she was still requesting a termination but had been advised that it was now too late for a termination and that she needed to book in for antenatal care.

**4.16** Children's social care phoned mother the same day. She confirmed that she had been advised that it was now too late for her to have a termination. She explained that she had sought a termination because of her health conditions, including epilepsy. She said that she had not yet booked in for antenatal care but planned to discuss this with her GP on 25th February 2020. She added that she felt that she should have stopped taking her epilepsy medication whilst pregnant and was to contact the epilepsy service for advice. Children's social care advised mother that a pre-birth assessment would need to be carried out due to the service's past involvement, which mother said she understood.

**4.17** On 17th February 2020, the social worker to whom the pre-birth assessment had been allocated made initial telephone contact with mother and also notified midwifery, advising them that mother was 24 weeks pregnant and had not yet received antenatal care.

**4.18** On 20th February 2020 mother's GP practice contacted midwifery to advise of mother's pregnancy and highlight that all her previous five children had been removed. The GP practice said that they had 'minimal information' as to why the children had been removed, adding that mother had told them it was because of father's previous involvement with the police. Mother was prescribed medication for epilepsy, asthma and morphine and mirtazapine for stomach pains.

**4.19** On 23rd February 2020 mother was seen by midwife 1 at her home address for booking in. Mother was noted to be 25 weeks pregnant. Health concerns were noted in

respect of smoking and opioid use. Personality disorder was also recorded although this was later confirmed with her GP to be self-diagnosed. Mother disclosed sexual abuse by her father. She also disclosed that she had previously tried to conceal a pregnancy by moving to Barnsley and using her sister's name in order to take the baby home. Nineteen animals were noted to be present at the home.

**4.20** On 28th February 2020 mother and father did not attend the scheduled pre-birth assessment meeting with the social worker.

**4.21** On 3rd March 2020 mother did not attend her first antenatal appointment and a new appointment was given. It had been planned that mother would also be seen by the substance misuse midwife at this appointment because of her long-term morphine use.

**4.22** On 4th March and 6th March 2020 mother and father did not attend scheduled pre-birth assessment meetings with the social worker.

**4.23** On 9th March 2020 children's social care discussed progressing the case to a strategy meeting and a Section 47 assessment in the light of the lack of engagement from the parents in the pre-birth assessment. It was decided to persist in attempting to engage them in the pre-birth assessment for a further short period.

**4.24** On 10th March 2020 safeguarding midwife 1 phoned the social worker to inform her that mother had not attended her first antenatal clinic appointment and had been sent another appointment for 25th March 2020.

**4.25** On 13th March 2020 mother did not attend a further scheduled pre-birth assessment meeting with the social worker which prompted a phone call to father who said that mother's ill health – severe migraines, vomiting, diarrhoea and stomach cramps – had prevented her attending appointments. However, father attended that day.

**4.26** On 24th March 2020 mother phoned the antenatal clinic lead to say that she would not be attending the 27th March antenatal clinic as she was asthmatic and had therefore chosen to self-isolate as a result of Covid-19 risks. Mother was offered antenatal care which would involve minimal contact with staff and other patients including being placed last on the list for clinic appointments.

**4.27** On 25th March 2020 the case was reviewed by the substance misuse midwife who, in addition to the information previously noted in this case summary, documented that mother had previously self-harmed and father had six children who were not in his care. The plan arrived at as a result of the review was for the substance misuse midwife to contact mother to provide reassurance around hospital care and to request a telephone strategy meeting as soon as possible.

**4.28** On 26th March 2020 the social worker contacted mother's epilepsy specialist who said that she had not been engaging with the service and appeared to have not taken any epilepsy medication since she became pregnant, despite continuing to take tramadol and morphine. (The epilepsy service had recently had further contact with mother's GP practice which had confirmed that mother had not collected epilepsy medication since October 2019 which contradicted mother's assertion that she had recommenced taking the medication). The epilepsy specialist explained that as mother suffered with tonic-clonic seizures in which she was likely to fall to the floor and convulse, continuing taking epilepsy medication was usually recommended as falls represented as much, or more, danger to the baby as the

medication. Mother's engagement with the epilepsy service continued to be 'poor and inconsistent'

**4.29** On 30th March 2020 midwife 1 rang and texted mother who texted a reply the following day to say that she would ring midwife 1 on Wednesday 1st April 2020 but did not do so. On Thursday 2nd April 2020 midwife 1 again rang and texted mother and received no reply.

**4.30** On Thursday 2nd April 2020 mother and father did not attend telephone appointments for the pre-birth assessment. Mother later sent a text saying that as she had been self-isolating her sleeping routine was 'all over the place'.

**4.31** On Wednesday 8th April 2020 the social worker and a colleague made home visits. After initially not being admitted, father answered the door to say that mother was in bed with abdominal pain and that the social worker needed to ring in advance of any visit.

**4.32** On Thursday 9th April 2020 the social worker made a home visit and saw mother and father. Mother appeared small for the stage of her pregnancy and she commented that she was usually larger by this stage of previous pregnancies. She said that she had been having a minimum of three seizures a week and all had resulted in unconsciousness for several minutes. She confirmed that she was not taking epilepsy medication which prompted a 'long conversation'. Mother told the social worker that her friend had advised her to deliver the baby at home so that no-one would know about it, allowing her to keep her baby. Mother added that she had no intentions of doing this and the social worker strongly advised against it. Father was said to 'look different' during the visit. When the social worker questioned his appearance, he said that he had taken two tramadol's that morning.

**4.33** Following the home visit, the social worker updated midwifery and the epilepsy team. The social worker said that mother had agreed to attend an antenatal appointment but was refusing to attend an appointment with the epilepsy team. The social worker said that she was writing a pre-birth assessment although mother had not attended any formal assessment sessions whilst father had engaged in only two sessions.

**4.34** On Friday 10th April 2020 midwife 1 scanned a private scan mother had had on 8th January 2020 into mother's patient record. The EDD had previously been calculated to be 18th June 2020 but on the basis of the private scan was then documented to be 4th June 2020.

**4.35** On Monday 13th April 2020 mother texted social worker to say that 'legal proceedings were not what they wanted' and that they would do anything to keep their baby and 'be a family' and prove that they were good parents. She described the prospect of the baby being removed at birth as 'devastating'.

**4.36** On Wednesday 15th April 2020 mother was seen by midwife 1 who referred her to the epilepsy nurse and transferred her to the care of a different obstetric consultant who specialised in epilepsy. Mother reported historic cannabis use. She said she was on anti-depressants but described her mood as 'good'. The EDD was documented as 18th June 2020 at this point which did not reflect the amended date of 4th June 2020 (see Paragraph 4.34). Mother was advised of the need to remain in hospital for between 3 and 5 days following the birth due to the baby's possible withdrawal from mother's prescribed morphine medication. A Medical Paediatric Alert referral form was completed relating to concerns with

Group B Streptococcus - which is the UK's most common cause of life-threatening infection in new born babies – and morphine use, which was sent to the paediatrician.

**4.37** On Thursday 16th April 2020 a safeguarding midwife contacted children' social care to request a birth plan as the due date had been altered to 4th June 2020. On the same day the safeguarding midwife also spoke to mother about creating a 'memory box' and 'life journal' following the removal of child W.

**4.38** On the same date (Thursday 16th April 2020) the epilepsy specialist advised social worker that she had spoken to mother and planned to support her to re-start her epilepsy medication. The relevant prescription was sent to mother's GP on 21st April 2020. The epilepsy specialist also appears to have suggested a multi-disciplinary team (MDT) meeting, although there is no indication that this was actioned.

**4.39** On Monday 20th April 2020 the pre-birth assessment was completed which recommended that Section 47 enquiries should commence and in parallel, legal advice should be sought. On the same date the Head of Service for children's social care consulted with Legal Services following which it was decided to issue Public Law proceedings at birth in respect of the unborn child W. When mother and father were advised of the pre-birth assessment recommendations, they requested a change of social worker and that further communication be sent to their 'legal team'.

**4.40** On Wednesday 22nd April 2020 mother did not attend an antenatal clinic appointment. On the same date health visiting were notified of the late booking pregnancy by midwifery.

**4.41** On Monday 27th April 2020 the police were called to a verbal argument between mother and father over their 16 dogs. The incident was assessed as a 'standard' risk. It was noted that there had been previous 'low-level' incidents between father and mother. Referrals to Independent Domestic Abuse Services (IDAS) were offered to both parties and apparently declined. No referral to children's social care appeared to be considered in view of mother's pregnancy.

**4.42** On Tuesday 28th April 2020 the health visitor contacted the social worker to ask about the outcome of the pre-birth assessment. Having been advised that the outcome was a decision to issue Public Law proceedings on the birth of child W, the health visitor advised that she would not be making antenatal contact with the parents. The social worker responded by saying that professionals should complete scheduled interventions.

**4.43** On Wednesday 29th April 2020 mother did not attend an antenatal clinic appointment and the following day the antenatal midwife tried to ring mother and left her a message.

**4.44** On Thursday 30th April 2020 a strategy meeting took place. The meeting took place virtually due to Covid-19 restrictions. A number of concerns were shared including:

- Mother and father had been known to children's social care and the police in South Yorkshire and elsewhere for a number of years.

- A number of children had previously been removed from their care and neither mother nor father had any of their children in their own care.

- Attempts had been made to conceal previous pregnancies and the couple were known to abscond which made timely reporting of concerns to children's social care 'paramount'.

- Father was known to the police for sexual and physical abuse of children, arson, possession of offensive weapons, fraud and harassment. Mother was known for threats to kill, harassment and drugs. It was also noted that the couple ran a dog breeding business from their home address which had attracted enforcement activity and complaints.

- Both mother and father had failed to meaningfully engage with services or with the pre-birth assessment in respect of the unborn child W.

- Mother's medical history was compounded by prescribed morphine.

**4.45** It was also documented that mother wanted to leave father and needed help to do this. She had texted the social worker that day saying that she needed to be assessed alone as her relationship with father had broken down. She added that she 'needed a house' which she was 'having difficulty with'. The reported incidents of domestic abuse were discussed, including indications of coercion and control by father.

**4.46** The outcome of the strategy discussion was that the unborn child W was at risk of suffering significant harm, that single agency Section 47 enquiries should be commenced by children's social care and an Initial Child Protection Conference (ICPC) should be convened. It was also documented that children's social care had decided to seek an Interim Care Order and remove the child from mother. Additionally, midwifery were to assess mother's mental health, screen her urine and she was to be referred to IDAS. A planned antenatal telephone contact by the health visitor with mother was also agreed at the meeting.

**4.47** On the same date (30th April 2020) duty social workers attempted to make a home visit but did not receive an answer.

**4.48** On Friday 1st May 2020 duty social workers made a home visit. Mother was present but not father. Mother declined a referral to IDAS as she said there was no domestic abuse, although there had been in the past. She added that father was 'fine' but 'distant' because of the involvement of children's social care. The social workers documented concerns about mother's presentation which was described as 'erratic' throughout.

**4.49** On Sunday 3rd May 2020 mother did not attend an antenatal appointment.

**4.50** On Monday 4th May 2020 mother sent the following text to social worker, 'Out of curiosity, what would your position be if I went at this alone?' The social worker responded by saying that she needed to speak with both mother and father.

**4.51** On Tuesday 5th May 2020 Section 47 enquiries concluded that an ICPC should be convened in light of the concerns.

**4.52** On Wednesday 6th May 2020 mother attended an antenatal appointment where she was reviewed by a consultant. Mother reported that she had begun to take epilepsy medication although she was not engaging with the epilepsy service. She continued with anti-depressants, morphine and used nicotine patches. A scan was completed. Reduced

amniotic fluid was noted. A drug test was performed and mother tested positive for opiates as expected given the morphine she was prescribed.

**4.53** On the same day (6th May 2020) children's social care sent the birth plan to midwifery who noted that the plan stated that children's social care were to be informed of the birth by midwifery; mother would have full time care of the baby whilst in hospital until the Interim Care Order was granted; assessment of care of the baby was required whilst on the ward; there were no restrictions on who could visit the baby although mother and father would need to be supervised closely given 'father's history and mother's health'; the baby would be discharged from the hospital to foster carers and police and children's social care were to be contacted at the point of discharge.

**4.54** On Thursday 7th May 2020 safeguarding midwife 1 contacted the social worker to request the birth plan to be amended to reflect the current Covid-19 restrictions in that no visitors were allowed to visit, father could be present during the birth but would be asked to leave shortly afterwards. Additionally, ward staff would not be able to provide 24-hour supervision of mother and baby but would provide routine postnatal care to mother and baby and endeavour to provide additional support when necessary. The 'additional support' contemplated appeared to be for mother and child W to be in a room next to the nurse's station with the door open so staff could have more oversight.

**4.55** Also on Thursday 7th May 2020 the social worker made a home visit to share the outcome of the pre-birth assessment with mother and father. Mother had rearranged the visit from the previous day and later sought to defer the 7th May visit but the social worker made the visit and spoke to mother. Father was absent. Mother's presentation during the visit was documented to be concerning and erratic.

**4.56** On Monday 11th May 2020 child W was allocated to a health visitor.

**4.57** On Tuesday 12th May 2020 the social worker made a planned home visit but received no answer.

**Wednesday 13th May 2020**

**4.58** Safeguarding midwife 1 contacted children's social care to advise that mother was in hospital and the birth was to be induced following concerns about reduced foetal movement which had arisen during her appointment with the consultant earlier that day. She requested a copy of the birth plan which was to have been amended following the discussions which took place on 7th May 2020. The birth plan was then sent to midwifery. It had not been amended to reflect the feedback made by midwifery on 7th May 2020 (Paragraph 4.54).

**4.59** Prior to going into hospital, it is understood that mother visited her GP practice in an effort to obtain her weekly morphine prescription in advance of the date on which it was due. Her request for the early prescription was refused. It is understood that she informed the GP practice that she was to be admitted to hospital for the birth of child W. However, maternity records indicate that the decision to induce the birth was taken *after* mother attended hospital for a scan so it is unclear how mother could have communicated the impending arrival of child W to her GP practice with any degree of certainty.

**Thursday 14th May 2020**

**4.60** Mother gave birth to child W during the early hours of the morning. Her friend supported her as father was documented to be 'unwell'. The baby was fit and well and she and mother were transferred to the antenatal postnatal ward. At this point the clinical recommendations were for increased observation from once per day to twice per day for mother as she had had a raised white cell count therefore the observations were initially hourly, then two hourly observations for child W for feeds and for review of neonatal abstinence syndrome (NAS). Maternity advised children's social care of the birth of child W.

**4.61** At 8am mother was reviewed by the substance misuse midwife, who discussed her current medications. It was explained to mother that she must only take the medication prescribed by the hospital and that any medication she had brought with her should be handed to staff for safe storage and dispensing. Mother said that she had only brought her Keppra (epilepsy treatment) and inhalers (asthma treatment) into hospital. The inhalers were left with mother to self-medicate as required. At this time, child W was appropriately dressed and nursed in the cot, where she was settled post feed. Safe sleep was discussed with mother as per Lullaby Trust guidelines (The Lullaby Trust raises awareness of sudden infant death syndrome (SIDS), provides expert advice on safer sleep for babies and offers emotional support for bereaved families).

**4.62** Later in the morning mother left the ward in her nightwear and took a taxi to her GP practice and collected her morphine prescription which she then took to the community pharmacy for dispensing before travelling back to the hospital by taxi. The GP practice is 4 minutes' drive from the hospital. The collection of the prescription from her GP practice was timed at 9.47am. Hospital staff were unaware that mother had left the ward for this purpose. The hospital had assumed responsibility for prescribing mother's medication for the period of her admission meaning that she was later also prescribed morphine from the hospital pharmacy which was unaware that her community prescription had been dispensed.

**4.63** From 2pm NAS monitoring of child W was adjusted to four hourly. However, maternity records state that child W was seen every two hours at a minimum.

**4.64** As neither parent would be able to attend – mother was in hospital with child W and father was unwell – and the Local Authority planned to make an application for an Interim Care Order, it was decided not to proceed with the scheduled ICPC that day. The ICPC would be reconvened as a matter of urgency should the Court not support the Local Authority's application.

**4.65** During the day the social worker spoke with mother who said that child W was of lower birth weight than her previous children and that she was having some difficulty feeding her. She said that whilst she did not agree with the Local Authority's decision, she did not intend to 'jeopardise anything'. She also reported a lack of communication with father, adding that he had told her that he did not want to go through the process of supervised contact with the child and 'all the emotional stuff' again. The social worker attempted to phone father but did not get a reply to her call.

**4.66** Ward staff noted that mother appeared to be in a 'good mood' and was regularly engaging with staff to ask for assistance with baby cares or to talk to them in general conversation. She was noted to frequently leave the ward, reportedly to speak to friends on the 'landing' who wanted to see the baby. Ward staff informed her that she should not be doing this due to Covid-19 restrictions. Child W was fitted with an ankle bracelet, as is routine for all new born babies on the ward, which allowed for monitoring of where the child was. Ward staff, who had been advised to be 'hyper vigilant' in case mother attempted to

remove the baby from the hospital, offered mother the opportunity to video call her friends so that they could see the baby. The possibility of calling security appeared to be under consideration.

**Friday 15th May 2020**

**4.67** Midwifery advised children's social care that mother and baby were doing well. The midwife had been caring for the baby whilst mother went to have an implant fitted (contraception) but usually mother was undertaking all care of child W independently and there were documented to be no concerns. Child W was showing no signs of withdrawal but the plan was for the baby to remain under observations for 5 days.

**4.68** During the morning the substance misuse midwife reviewed mother and noted that she presented well and was not in a sedative state. The substance misuse midwife again discussed mother's medication with her and she confirmed she only had her inhalers and the Keppra. Mother was advised to give the Keppra to the midwife providing care to her. Mother questioned her morphine prescription stating that the dose had changed. The specialist Midwife reviewed the prescription as there was a discrepancy between what mother was saying and what was to be prescribed. The substance misuse midwife paused the morphine until the dose was confirmed by the GP practice. Mother consented to the substance misuse midwife calling her GP practice to seek clarity in respect of her prescribed medication. At this point it was again reiterated to mother that she must only take the medication the Hospital prescribed. The GP practice was informed that mother had given birth and was currently an in-patient. This contact with mother's GP was also prompted in part by her request for codeine in addition to her prescribed morphine which was considered unusual given that she had had a normal vaginal delivery and was taking morphine.

**4.69** The social worker phoned mother who requested support to find alternative housing away from father because their relationship was 'over'. She said that she had lost her children and twelve years of her life because of father and insinuated he had been unfaithful to her earlier in the year. She added that he had shown no interest in this pregnancy and she was also worried about him neglecting their dogs whilst she was away from home. She said that she planned to stay with a friend following her discharge from hospital. (This appears to have been the same friend who was present during the birth of child W).

**4.70** Following the phone call with mother, the social worker emailed safeguarding midwife 1 to advise that the Court paperwork had been completed which was with management for approval, and carers for child W had been identified. The social worker added that she had spoken to mother by telephone and she had been very tearful and asked hospital staff to 'check in' with mother over the weekend as she seemed isolated. The social worker also advised that mother had told her that she didn't want father to have contact with the baby after the Interim Care Order had been secured.

**4.71** The social worker submitted her statement and the care plan for child W to Legal Services and this was then transmitted to the Court.

**4.72** During the afternoon ward staff noted that child W had been left in their room alone by mother and had begun to cry. Mother was noted to be off the ward for an hour.

**Saturday 16th May 2020**

**4.73** During the night (Friday/Saturday) ward staff noted mother to be tearful. She said she had had an argument with father and that she had been 'thrown out' of the house she shared. She was also worried about their 16 dogs. However, she was noted to be caring for child W independently and asking questions 'relevant' to the care of the child.

**4.74** At approximately 7.45pm mother ran out of the side room saying the baby was unresponsive. She said that she had fallen asleep with the baby at approximately 6.30pm and woke to find the baby unresponsive although this was not witnessed by staff. Extensive neonatal resuscitation commenced but child W was found to be critically ill after apparently being over laid by mother.

**Sunday 17th May 2020**

**4.75** A virtual strategy discussion took place and a Police Protection Order was taken out as an interim measure in advance of the Interim Care Order, which was granted by the Court the following day.

**4.76** Child W died on 14th September 2020 following a High Court judgement that she be transferred to palliative care.

## 5.0 Family contribution to the review

**5.1** At the time of writing both mother and father were subject to a criminal investigation which precluded offering them the opportunity to contribute to the review at this time.

## 6.0 Analysis

### History of concealed pregnancies

**6.1** Both mother and father have a number of children – mother has five and father has eleven -none of whom are in their care. They also have a history of attempting to conceal pregnancies from the authorities in order to prevent new born children being taken into care, including travelling from Durham to Barnsley in 2013 to enable mother to give birth in an area in which the couple were not known to services.

**6.2** Given this history, and the high risks which mother and father may present to children conceived by mother, local agencies could have responded to initial information that mother was pregnant with child W with more alacrity. Additionally, an earlier pregnancy, which it is assumed did not progress to full term, did not generate any curiosity by the police or consideration of a referral (Paragraph 4.4).

**6.3** Mother's pregnancy with child W was first noted by I-HEART Barnsley - which provides out of hours GP services - on 30th October 2019, when it is estimated that she would have been around two months pregnant. It is not known whether I-HEART had access to any information which could have generated concern about the pregnancy, but this pregnancy was recorded in mother's patient record which was picked up both by her GP and the epilepsy service (Paragraph 4.8). Although the epilepsy service were not aware of the fact that all mother's previous children had been removed from her care at that stage, the GP practice was aware of this fact (Paragraph 4.18) although the fact that mother's stated intention was to have a termination seems likely to have diminished the GP's perception of safeguarding concerns for the unborn child.

**6.4** However, the GP practice could have considered a safeguarding referral, or at least initiated a conversation with children's social care, when doubts about mother's intention to follow through with the termination arose from 19th December 2019 (Paragraph 4.13). The epilepsy team could also have considered a discussion with SWYPFT's safeguarding team, a safeguarding referral, or contact with children's social care, when mother's GP advised them that her previous five children had been removed from her care for 'safeguarding reasons' (Paragraph 4.13).

**6.5** Given the compressed time period subsequently available to partner agencies to safeguard the unborn child W - from 12th February until 14th May 2020 – it would have been helpful for children's social care and partner agencies to have been given the earliest possible notification of mother's pregnancy.

**How comprehensive was the assessment of mother, father and the unborn child W?**

**6.6** As stated above, there was not an abundance of time for children's social care to conduct a pre-birth assessment and then address the concerns arising from that assessment prior to the birth of child W. The time available was reduced when mother's estimated date of delivery was re-calculated from 18th June to 4th June 2020 and when child W was actually delivered even earlier on 14th May 2020.

**6.7** The lack of time available to partner agencies was compounded by what appears to have been deliberate efforts by mother and father to evade contact with children's social care and maternity services. Mother and father failed to attend the first four in-person pre-birth assessment appointments with the social worker and when telephone appointments took place as a result of Covid-19 restrictions, they were equally elusive. Additionally there was no answer to three out of four home visits made by the social worker. Nor did mother attend the five antenatal clinic appointments maternity offered to her during March and April 2020, although she was under no legal obligation to attend these.

**6.8** Maternity offered mother support in an effort to encourage her to attend the antenatal clinic appointments, including funding a taxi, placing her last on the list for clinic appointments so that she could have as little contact with staff and other patients as possible, given her concerns that her asthma put her at increased risk should she contract Covid-19. She was also assured that the enhanced personal protective equipment was being used. Additionally, midwife 2 attempted to contact mother to provide reassurance around the care offered to her by the hospital.

**6.9** The social worker escalated the case to management on 9th March 2020 when it was decided to persist in attempting to engage with the parents rather than progress to a strategy meeting and a Section 47 assessment at that time. Whilst it was not unreasonable to allow a little more time for the parents to engage, it was a further 7 weeks before the strategy meeting took place. From the outset it seemed unlikely that mother and father would be able to demonstrate that meaningful change had taken place since the previous attempt to deceive agencies about the birth of a child in 2013, albeit 7 years had elapsed. As such, there was a growing inevitability about the need for a strategy meeting and it would have been more appropriate to progress to a strategy meeting at the earliest opportunity. The case was also escalated by maternity services and following a review by the substance misuse midwife on 25th March 2020, she decided to request a telephone strategy discussion as soon as possible.

**6.10** Despite the very limited engagement from mother and father, the pre-birth assessment was completed by 20th April 2020 which led to decisions to commence Section 47 enquiries and to issue Public Law proceedings upon the birth of child W.

**6.11** In their contribution to this review, children's social care state that the very limited engagement of mother and father adversely affected the pre-birth assessment. In particular the service's understanding of the relationship between mother and father was largely based on historical information and there were a number of 'unknowns'. It is concluded that this is a balanced view of the comprehensiveness of the assessment of mother, father and the unborn child W.

**How effectively were any risks mother may present to child W assessed and managed, including the risks associated with co-sleeping?**

**6.12** A virtual strategy meeting took place on 30th April 2020 which appears to have been the first time that all risk information was shared because during the meeting the social worker noted that she had previously been unaware of the risk that father had previously carried weapons and had been attempting home visits unaccompanied.

**6.13** The minutes of the strategy meeting document that a very substantial amount of risk information was shared. For example the police said that their researcher had compiled a 30 page document detailing incidents involving father and mother. The risk information was eventually distilled down into the following concerns:

- 'Historic criminality'
- 'Domestic violence'
- 'Historical children removed from parents' care'
- 'VISOR – encouraging sexual act of 13 year old boy'
- 'Not engaged epilepsy, social care, antenatal services'
- 'Substance use'
- 'Concern for health of baby'
- 'Concerns regarding health of mother'

**6.14** With the benefit of hindsight, the specific area of risk which led most directly to child W's death was mother's use of opiates and possible dependence and the history of what appears to have been 'drug seeking behaviour' by herself and father. The primary source of information about this area of risk was mother's GP practice, which was not represented at the strategy meeting. However, midwifery highlighted 'historical' records from mother's GP practice, which were said to 'possibly' relate to her last pregnancy, which indicated that she had been extremely abusive when not able to obtain morphine based drugs from the GP practice. Additionally the police informed the meeting that an unknown female (who may, or may not have been mother) in company with father altered a prescription and attempted to get it dispensed in Sheffield in August 2019. The police also described father as a cocaine user.

**6.15** During the meeting the social worker said that father appeared to have a glazed expression when she saw him which prompted a discussion of whether he could also be using mother's pain relief medication, which she was noted to be prescribed 'a lot of'. Concerns about both father and mother's presentation – on the rare occasions on which it had been possible for them to be observed by professionals – (Paragraphs 4.32, 4.48 and 4.55) was thought to be a possible indicator of substance misuse.

**6.16** The only risk that mother's use of morphine was considered to present to child W was the risk to the child of withdrawal symptoms from the drug. One of the many actions arising from the strategy meeting was for midwifery to conduct urine screening of mother. Mother's opioid use had been noted as a 'health concern' at her maternity booking-in appointment and it had been planned for her to be seen by the substance misuse midwife earlier (Paragraph 4.21), but this was finally accomplished when mother attended an antenatal clinic appointment on 6th May 2020 and tested positive for opiates (Paragraph 4.52).

**6.17** Arguably more weight could have been given to mother's use of painkillers, including morphine and her and father's drug seeking behaviours but in fairness to the professionals who attended the strategy meeting, there was an unusually substantial risk history to consider in this case. In attempting to make sense of this substantial risk history, it may have been helpful to have a clearer focus on the risks to child W during the periods prior to, and following, her birth. During the period prior to her birth, there were a wide array of risks such as the risk of the parents absconding, mother's compliance with her epilepsy medication which increased her risk of seizures, the risk of domestic violence and abuse by father on mother, and their lack of engagement with both health and social care professionals. Following the birth, the range of risks to child W narrowed somewhat. For example the risk of mother absconding with the child was mitigated by the oversight of medical professionals on the ward and the fact that the ankle bracelet worn by child W would trigger an alarm if mother attempted to remove her from the ward.

**6.18** The review has received no information to indicate mother's use of painkillers including morphine and her drug seeking behaviour informed any safe sleeping risk assessment for the period in which mother would be caring for child W in hospital. There is no indication that a safe sleeping risk assessment was carried out. Normally such a risk assessment would have been carried out as part of the new birth visit by the health visitor. No such postnatal visit was scheduled to mother as it was understood by all professionals involved in the case that, assuming the Interim Care Order was granted, mother would not be taking child W home with her. As previously stated safe sleeping advice was provided (Paragraph 4.61).

**6.19** It seems likely that no safe sleeping risk assessment was considered because it was anticipated that child W would be in the care of mother for only a short period and this brief period of maternal care would take place within the maternity ward of a hospital where mother and baby would be regularly observed and cared for by medical professionals. Many of the factors known to increase risk of sudden unexpected death in infancy from co-sleeping would not be present in a maternity ward environment such as parental smoking, sleeping on a sofa or armchair, sharing a bed with the baby or overcrowding. However, parental substance use is a factor known to increase the risk of death from co-sleeping and although the hospital assumed responsibility for the prescription and administration of drugs to mother, a hospital is not a secure environment and there was nothing to stop mother leaving the ward from time to time, nor was there any means of exerting control over who she made contact with when absent from the ward, nor was there any means of monitoring of any substances she obtained whilst absent from the ward.

**6.20** SWYPFT has advised this review that from the discussions which took place at the strategy meeting, it was the perception of the epilepsy team that mother would not be involved in the care of child W post-delivery. Had it been understood that mother would be caring for child W for a time, a risk assessment should have been completed by the epilepsy team. This normally takes place at 32 weeks, although mother was not engaging with the epilepsy team at that time.

**6.21** It is worthy of note that the nationally mandated antenatal visit by the health visitor (1) did not take place in this case. There had been some discussion between professionals as to whether the antenatal visit was necessary given that child W was to be removed from mother's care shortly after birth, but ultimately it was decided that all scheduled interventions should be completed (Paragraphs 4.42 and 4.46). In the event, no antenatal visit to mother was completed, possibly because of the compressed time period during which professionals were aware of mother's pregnancy.

**6.22** Whilst some of the issues expected to be addressed during the health visitor antenatal visit would not have been relevant to mother and father, such as the explanation of the health visitor offer; a family needs health assessment, emotional support and infant feeding would have been relevant and could have informed oversight of the care of child W by mother in hospital.

**6.23** It is worthy of note that this is the third Barnsley LCSPR completed by this independent reviewer in which the antenatal visit was not completed including two cases in which very young babies died.

**6.24** It is concluded that the risks arising from mother's use of morphine and possible dependence and the history of what appears to have been 'drug seeking behaviour' by herself and father were insufficiently articulated and explored. This risk was overshadowed by other risks mother and father were considered to present to child W. Whilst clarifying risks was made more challenging by the limited engagement of mother and father in the pre-birth assessment and the compressed time window available to professionals, it may have been helpful to have a clearer focus on the risks to child W during the periods prior to, and following, her birth. A safe sleeping assessment should have been carried out for the period in which mother cared for child W in hospital.

**How effective was the Birth Plan for child W? Did the Birth Plan address any interval between birth and the removal of the child from her parents?**

**6.25** The birth plan documented a number of concerns from father and mother's history but did not always specify which concerns related to which parent and those which applied to both parents. For example 'being a perpetrator of domestic abuse/violence' and 'domestic abuse within the couple's relationship' were included in the documented concerns but it was not stated which parent was perceived to be the perpetrator and which the victim. Additionally 'substance misuse history' was documented but no further details were provided. Looking back, children's social care and BHNFT both feel that the birth plan should have specifically addressed mother's capacity to parent child W safely and any risks mother may have presented to child W.

**6.26** The birth plan went on to state that 'the couple need to be supervised closely given father's history and mother's health needs'. 'Supervised closely' was not defined.

**6.27** An opportunity to clarify the level of supervision required arose when safeguarding midwife 1 requested the amendment of the birth plan to reflect the impact of Covid-19 restrictions – which would limit father's presence in the hospital to the delivery only – and pointed out that 24 hour supervision of mother and baby would not be possible. Safeguarding midwife 1 went on to state that routine postnatal care would be provided to mother and child W and that ward staff would endeavour to provide 'additional support', which appeared to consist of locating mother and child in a room next to the nurse's bay with the door open which would facilitate more oversight (Paragraph 4.54).

**6.28** Four working days after safeguarding midwife 1 requested the amendment of the birth plan, mother was admitted to hospital for the birth of child W. The birth plan had not been amended as requested by safeguarding midwife 1 and there is no indication that any discussion took place to further consider the level of supervision required during the period in which mother would be caring for child W in hospital. This meant that the birth plan was not fully fit for purpose and provided insufficient clarity to the staff likely to come into contact with mother and child W during their 3-5 day stay on the postnatal/antenatal ward.

**6.29** It would have been beneficial to formally document the level of supervision required of mother and the new born child W. If the level of supervision could not be provided by the hospital, then this would have necessitated consideration of how mother and child W were to be supervised whilst in hospital.

**6.30** Father's exclusion from the hospital - except for the period of the birth - appeared to reduce some of the risks documented in the birth plan but the plan was not revised to document how his absence from the ward affected the risks he could present to child W, mother and professionals. Had this been done it could have led to consideration of the risks he could continue to present remotely.

**6.31** It is concluded that the birth plan did not sufficiently define the level of supervision required for mother and child W and was not revised to reflect the changes to father's contact with mother and the new born baby.

**Did the earlier than anticipated delivery of child W impact upon the implementation of the Birth Plan in any way?**

**6.32** The earlier than anticipated delivery of child W further compressed the time professionals had to engage with mother and father and take the action necessary to safeguard child W. As stated above, the earlier delivery reduced the time available for the birth plan to be revised to reflect the points made by safeguarding midwife 1 on 7th May 2020 (Paragraph 4.54).

**6.33** The recalculation of the EDD does not appear to have had any effect on pre-birth planning as the revised EDD of 4th June 2020 was communicated by midwifery to children's social care on 16th April 2020 (Paragraph 4.37) which was well in advance of the strategy meeting.

**How effective were the actions taken to safeguard Child W following her birth?**

**6.34** In parallel with the birth plan, observations were made to check on medical matters such as neonatal abstinence syndrome (NAS) which afforded regular opportunities to interact with mother and child W. The observations provided on the ward went above and beyond what would be expected on a busy antenatal/postnatal ward. For example, when the need for NAS monitoring was reduced to four hourly checks, midwifery continued to check on child W every two hours.

**6.35** Father was not present for the birth and so maternity staff were not required to manage any implications arising from his physical presence on the ward. However, there did not appear to be any consideration of the risks he could present through remote contact with mother, either by phone, text or physical contact during mother's frequent absences from the ward.

**6.36** The identity of the friend who supported mother during the birth has not been shared with this review but it is understood that she may have been the friend who advised mother to deliver the baby at home 'so that no-one would know about it' (Paragraph 4.32). If this friend was also one of the friends mother frequently left the ward to speak to following the birth of child W, it is conceivable that the presence of the friend could have increased the risk that mother would attempt to abscond from the ward with the baby. Any risks associated with the friend do not appear to have been considered.

**6.37** Ward staff noted no issues with mother's personal care of child W, although concerns arose over an apparent deterioration in her relationship with father, the amount of time she was spending off the ward during which she left child W alone for an hour on one occasion and her periodic tearfulness which was linked to relationship problems with father but may also have been connected to the imminent removal of child W from her care which may have triggered memories of past removals of children from her care.

**6.38** It is concluded that efforts to safeguard child W following her birth were compromised by a birth plan which was insufficiently specific about risks and the level of supervision required and an assumption that the maternity ward of a hospital was an unequivocally safe place for child W.

**How effective was the Child Protection Plan for child W?**

**6.39** There was insufficient time to complete a child protection plan for child W. On 30th April 2020 it was decided that an ICPC would be convened following the completion of Section 47 enquiries. The latter enquiries were completed in three working days and these confirmed the need for an ICPC.

**6.40** The ICPC was scheduled for 14th May 2020 which was over two weeks before mother's EDD. However, as she gave birth in the early hours of the same day and was therefore not available to attend the ICPC, and father was said to be unwell, it was decided not to proceed with the ICPC on the understanding that it would be reconvened as a matter of urgency should the Court not support the local authority's pending application for an Interim Care Order.

**6.41** Deferring the ICPC denied professionals the opportunity to further discuss the case which could have been beneficial given the fact that only one multi-agency meeting had taken place – the strategy meeting held on 30th April 2020.

**6.42** Whether or not the ICPC went ahead there would have been benefit in following the strategy meeting with a further multi-agency meeting to ensure the actions arising from the strategy meeting had been completed, further clarify risks and the action necessary to mitigate those risks. In their contribution to this CSPR, the police state that they contacted children's social care to suggest referring father to the Multi-Agency Public Protection Arrangements (MAPPA) to further consider his risk of violence and coercive control, but that this was not progressed. The police also felt that there could have been benefit in having a 'trigger plan' should it become necessary to consider taking more urgent steps to protection child W, through a Police Protection Order (PPO) for example.

**Given that Care Proceedings could not be heard until 4 days after the birth of child W at the earliest, should more urgent action to remove child W have been considered?**

**6.43** Child W was born on Thursday 14th May 2020, the application for an Interim Care Order was made the following day and heard by the Court on the next working day – Monday 18th May 2020.

**6.44** Children's social care have advised this CSPR that, had imminent and immediate risks to child W been identified, an application could have been made for an Emergency Protection Order. They added that as no immediate safeguarding risks had been identified in respect of maternal care of the child, such as previous deliberate harm to children, or concerns regarding mother's basic care of the child which would put her at risk, the threshold for this Order was not met. Discussion between children's social care and the local authority's legal services confirmed this position at the time. However, the difficulties experienced in completing a sufficiently thorough pre-birth assessment left children's social care in a position where they could not take a well-informed view on 'imminent and immediate' risks.

**6.45** Given the hospital's plan was for child W to remain in hospital for 3-5 days to monitor withdrawal of the baby from mother's opioid use, children's social care decided that it was appropriate for the child to remain in mother's care on the antenatal/postnatal ward for this period which would allow the Interim Care Order to be obtained and the child then to be placed with foster carers.

**6.46** At the practitioner learning event arranged to inform this LCSPR it was said that arrangements such as this were fairly common prior to the death of child W and that there would often be negotiation between children's social care and the hospital to enable the new born baby to remain in the care of their mother in the hospital until the Interim Care Order had been obtained. In child W's case there was an entirely legitimate medical reason for the baby to remain in hospital for 3-5 days (observation of NAS), but in other cases the hospital was previously usually prepared to accommodate a request for the mother and the child to remain on the ward until the Interim Care Order had been obtained – providing there was no immediate risk to the baby. Often the parent's solicitor would have been consulted and it was usually felt to be in the interests of all parties for the mother and baby to remain on the ward whilst the Interim Care Order was sought as opposed to making application for an Emergency Protection Order or the use of police powers. In their contribution to this LCSPR children's social care state that it would have been very rare for the local authority to provide supervision to a mother and baby whilst on the ward unless there was a direct risk to the baby. In child W's case this was not considered at any point but the service accepts that, on reflection, it should have been in this case.

**6.47** The practitioner learning event was advised that since the death of child W an entirely different approach is taken and that 1:1 supervision of mother and baby on the ward is now arranged until the Interim Care Order is obtained. It is understood that 1:1 supervision is provided by the hospital -  from the NHS Staff Bank from which temporary staffing is drawn for increases in demand or staff shortages – and funded by the local authority. This arrangement is agreed prior to the birth for the baby to ensure a quick and robust plan of care to ensure the baby is safeguarded.

**6.48** It is difficult to escape the conclusion that prior to the death of child W 'custom and practice' was that a new born baby would remain in hospital with their mother until such time as an Interim Care Order had been obtained and that was generally perceived to be in the best interests of all parties. No application could be made to the Court until the birth of the baby which conferred a legal existence on the child and the hospital was perceived as a

place of safety and the time the mother spent with the new born baby on the ward had the potential to alleviate the trauma associated with removal to an extent.

**Was safe sleeping advice given to mother?**

**6.49** Whilst mother was in hospital following the birth of child W safe sleeping was discussed with her on the day on which the baby was born and on subsequent occasions and there appeared to be no reason to doubt mother's ability to understand this information. Normal practice would be for safe sleep to be discussed again prior to discharge.

**6.50** The hospital records indicate that child W was in her cot, the incubator or in mother's care at all times. When mother was off the ward, the baby was always found in safe sleeping positions.

**How effective was the supervision of mother and child W on the postnatal ward, including:**

- **'specialing' (enhanced observation of a patient)**
- **how health care workers perceive risk and act on this**
- **the risk assessment documentation**
- **the handover between shifts**
- **the role and input of the BHNFT safeguarding team**

**6.51** Mother's care of child W was continually assessed and documented within records, and no specific concerns raised. Nor were there any concerns about mother's presentation when she was on the ward, appearing attentive, coherent and alert. She appeared to be meeting the baby's needs.

**6.52** There were clear verbal and written handovers. Observation times were clearly documented within the records and also included when the next observations were due.

**6.53** Staff attempted to record when mother was off the ward for long periods – as requested by children's social care – but as she was not observed 24 hours per day, it was difficult for staff to always be aware of mother's whereabouts in a busy ward environment. Mother did not always advise staff when she was leaving the ward. Additionally, staff did not always record whether mother was present when they observed the baby.

**6.54** The BHNFT Safeguarding Team were involved with the care and assessment of mother and baby and provided advice to staff on issues such as the impact of mother's opioid use on the unborn child and possible withdrawal symptoms following birth. However, they did not become aware of any substance misuse by mother. This was an issue which was discussed with her at those antenatal appointments which she attended. As previously stated, the BHNFT Safeguarding Team raised questions in respect of the Birth Plan although these had not been resolved prior to the birth of child W.

**Was the prescribing of oral morphine to mother by her GP in accordance with expected policy and practice?**

**Was the dispensing of oral morphine to mother by the hospital pharmacy in accordance with expected hospital policy and practice? Should there have been any communication between the hospital pharmacy, the postnatal ward and the GP?**

**6.55** The chronology submitted to this review by mother and father's GP practice was extremely limited. Further information was provided by the CCG at the practitioner learning event and it has been possible to piece together mother and father's contact with their GP practice by using information from chronologies from partner agencies where that agency had been in contact with the GP practice. A number of questions were submitted to the GP practice following the practitioner learning event and the responses to these questions have informed this report.

**6.56** It is understood that mother had been prescribed morphine for abdominal pain since 2015 and that her GP became concerned about mother developing an opiate dependency and discussed a referral to specialist support which she declined. She collected morphine weekly and would regularly attempt to collect it early as she appears to have done just prior to her admission to hospital to give birth to child W (Paragraph 4.59). When her requests to collect morphine early were declined, mother could be verbally aggressive to reception staff at the GP practice. As previously stated, there is further evidence of drug seeking behaviour by mother and father which on one occasion was accompanied by threatening behaviour towards the GP (Paragraph 4.10).

**6.57** Having been admitted to hospital, administrative responsibility for prescribing and administering the morphine was assumed by BHNFT, which was explained to mother (Paragraphs 4.60 and 4.68).

**6.58** Mother's appearance at both her GP practice and then her pharmacy (it had initially been thought that mother collected the morphine prescription from her GP practice and then returned with it to the hospital where it was dispensed by the hospital pharmacy but it has since been confirmed that the morphine prescription was dispensed by her community pharmacy) in her nightwear and possibly displaying evident signs that she was a hospital patient could have caused questions to be asked by the staff who came into contact with her at the GP practice and the pharmacy. Mother's GP practice has advised this review that when she collected her prescription on 14th May 2020 this was her regular weekly prescription day. Reception staff did recall the event as mother was well known to them because of aggressive behaviour when previously attempting to obtain prescriptions early. Reception staff noted that she was wearing nightwear but this was not considered particularly unusual because some patients attend the GP practice wearing dressing gowns for example.

**6.59** The hospital was unaware that mother had travelled from the hospital to her GP practice and pharmacy to obtain her morphine prescription. This CSPR has been advised that there is no process for pausing GP prescriptions whilst a patient of that GP practice is admitted to hospital. The CSPR has also been advised that pausing GP prescriptions for women admitted for child birth would not be a realistic aspiration given the short period of time women usually spend in hospital to give birth.

**6.60** In this case, midwifery telephoned mother's GP to check on the correct dose of morphine mother required. This contact was prompted in part by mother's request for additional pain relief which was considered unusual given the fact that had experienced a normal vaginal delivery (Paragraph 4.68). This telephone contact presented a potential opportunity for mother's GP practice to have noticed that mother had collected her morphine prescription the day before and also to have discussed her previous drug seeking behaviour. The GP practice advise that mother's medical notes contain no record of the call from midwifery. However, the GP practice has advised this review that it is not common

practice to check a patient's medical collection history when informed of their hospital admission.

**6.61** Following this contact with her GP, midwifery explained the risk of taking non-prescribed medication to mother (Paragraph 4.68) although it is not known whether this explanation explicitly linked the risk of taking non-prescribed medication with increasing the risk of death of an infant from co-sleeping.

**6.62** Overall, mother's presentation whilst in hospital caring for baby W appears to have been largely accepted at face value by maternity staff. There appears to have been little or no weight given to her previous attempts to manipulate and deceive professionals. In their contribution to this CSPR, BHNFT have stated that their staff were unaware of mother's dishonesty and were unduly trusting of what she reported. Mother was not documented to appear sedated at any stage and false reassurance was provided by the fact that mother did not fully take all of the morphine prescribed by the hospital pharmacy.

**How effectively were any risks father presented to child W, directly or indirectly, managed? Did the fact that Covid-19 restrictions largely precluded his presence in hospital affect practitioner's appreciation of the risk he may present to child W?**

**6.63** As previously stated, father was not present for the birth and so maternity staff were not required to manage any implications arising from his physical presence on the ward. As previously stated, there did not appear to be any consideration of the risks he could present through remote contact with mother, either by phone, text; or possibly through physical contact during mother's frequent absences from the ward. Nor were the risks father presented reviewed in the Birth Plan once children's social care was advised that he would only be allowed to be present on the ward for the birth.

**Did practitioners consider the possibility that father could exercise coercive control over mother by telephone or other means?**

**6.64** There was a history of domestic abuse in the relationship between father and mother. Locally, the police had been called out to domestic abuse incidents since 2013. The incidents frequently consisted of verbal arguments but also involved violence by father (Paragraphs 4.3 and 4.4). Additionally, a DASH risk assessment completed in the year prior to the birth of child W indicated longstanding coercive and controlling behaviour by father (Paragraph 4.4).

**6.65** Mother declined referrals to IDAS (Paragraphs 4.41 and 4.48) but just prior to the birth of child W (Paragraph 4.45) and immediately following the birth (Paragraph 4.69), she disclosed to the social worker that her relationship with father had broken down and she needed support to move away from him. However, mother had also asked the social worker whether she might be allowed to keep child W if she was no longer in a relationship with father (Paragraph 4.50) which suggested that mother may have had an ulterior motive in presenting as someone who wished to leave an abusive relationship.

**6.66** However, father's ability to coerce or control mother by phone, social media or by meeting her during her frequent absences from the antenatal/postnatal ward could have been given greater consideration. It would certainly have been prudent for hospital security to have been briefed to look out for his presence on the hospital site and for mother to have been asked about any contact from father.

**Did restrictions imposed as a result of Covid-19 impact in any way on measures necessary to safeguard Child W?**

**6.67** The first Covid-19 lockdown in England commenced on 23rd March 2020 which was six weeks after children's social care and maternity services became aware of mother's pregnancy with child W. The lockdown restrictions remained in place throughout the period during which child W was born and then sustained the injuries which later ended her life.

**6.68** Although the Covid-19 restrictions had significant implications for the manner in which all agencies in contact with mother, father and child W delivered their services, there is no indication that the restrictions had an adverse effect on efforts to safeguard child W, other than the aforementioned possibility that the physical absence of father from the hospital ward, in compliance with Covid-19 restrictions, may have provided agencies with a false sense of assurance that he was not in a position to influence mother's behaviour or harm child W.

**6.69** Mother's stated fears of Covid-19 as a pregnant woman who suffered with asthma were accepted at face value and maternity services offered appropriate adjustments to her antenatal clinic appointments in an effort to assuage her concerns.

**Is the learning from this LSCPR consistent with the learning from the National Panel Review of Sudden Unexpected Death in Infancy?**

**6.70** The National Child Safeguarding Practice Review Panel oversaw a review entitled 'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm' (2), hereinafter referred to as 'the SUDI review'. SUDI cases represented one of the largest groups of cases notified to the National Panel and involved parents co-sleeping in unsafe sleep environments with infants, often when the parent had consumed alcohol or drugs. Additionally, there were wider safeguarding concerns in these cases – often involving cumulative neglect, domestic violence, parental mental health concerns and substance misuse.

**6.71** Whilst the case of Child W has many of the features of the cases considered by the SUDI review, the key difference is that the child's death arose as a result of co-sleeping with her mother in an environment which would not be considered unsafe i.e. on a maternity ward whilst being monitored closely by maternity staff.

**6.72** As in the case of a recent Barnsley CSPR in respect of child X, the indications of mother's substance use are more evident in hindsight than they were to professionals at the time. Taken together, the cases of child W and child X strongly indicate that a much greater emphasis should be placed on the thorough exploration of maternal substance use and the risk of death to any infant the mother intentionally or inadvertently co-sleeps with. In child W's case there were indications of opiate dependence, drug seeking behaviour accompanied by dishonesty, manipulation and threats and a long track record of engaging with services only on her terms. Unfortunately, much of the information about substance use and drug seeking behaviour was held by mother's GP practice which was only indirectly involved in the multi-agency efforts to safeguard child W and the information available to professionals about mother's substance use was distinctly overshadowed by other more obvious risks.

**6.73** The SUDI review arrived at the following three conclusions:

- Professionals needed to obtain a better understanding of parental perspectives in order to develop a supportive yet challenging relationship which facilitates more effective safer sleep conversations.
- Work to reduce SUDI needs to be embedded in multi-agency working and not just seen as the responsibility of health professionals.
- The use of behavioural insights and models of behaviour change to support interventions to promote safe sleeping need to be explored.

**6.74** Applying these conclusions to the case of child W, mother - and father's - marked reluctance to engage with professionals severely limited any understanding of their perspective, which could not be taken at face value in any event. This case also indicates that there is further work to be done to embed work to reduce SUDI in multi-agency working. For example, mother did not receive safe sleeping advice from the social worker who conducted the pre-birth assessment. Achieving behaviour change was not a professional focus in this case given the decision to remove child W from the care of her parents.

**Good practice**

**6.75** There was much good practice in this case.

**6.76** During November and December 2019 the epilepsy team was very proactive in contacting mother and her GP practice in an effort to ensure her epilepsy was appropriately managed at a time when it was unclear whether she intended to go ahead with a termination of her pregnancy (Paragraphs 4.11 and 4.12).

**6.77** BPAS made appropriate contact with children's social care when it became clear that terminating her pregnancy with child W was no longer possible for mother (Paragraph 4.15).

**6.78** Children's social care responded promptly to the referral from BPAS by contacting mother and notifying midwifery (Paragraph 4.16).

**6.79** The social worker made very diligent, tenacious and persistent attempts to engage mother and father in the pre-birth assessment.

**6.80** Maternity services were flexible in making a home visit to mother for the booking-in appointment and offering mother support, reassurance and a more personalised service in an effort to engage with her and address her stated fears in respect of Covid-19.

**7.0 Findings and Recommendations**

**7.1** The death of new born child W was a truly shocking event. She sustained the injuries from which she later died whilst within a hospital maternity ward in which she was being cared for by her mother for a short period whilst an interim Care Order was obtained to enable the removal of the child from her parents. Partner agencies had recognised that child W was at risk of significant harm and had worked together for the express purpose of safeguarding the child.

**7.2** The death of a baby in such circumstances also appears to be a very rare event. The independent reviewer has been unable to find a similar case in the NSPCC CSPR repository. The death of child W prompted urgent review activity locally and a number of policies and practices have been strengthened in advance of this LCSPR report being concluded,

including the provision of 1:1 support to mothers and new born children in hospital where it has been decided to remove the child as soon after birth as logistically possible.

**7.3** Notwithstanding the changes already made, there is considerable additional learning from this case which is reflected in the recommendations set out below. The assumption that a hospital environment is unequivocally a place of safety for a new born infant has been challenged. Until the death of child W, it was 'custom and practice' for a baby it was intended to remove at birth to remain in the care of the mother on the maternity ward until such time as an Interim Care Order could be obtained. It seems likely that this remains the approach taken elsewhere, given the lack of any nationally agreed standards. Therefore the first recommendation is that the learning from this CSPR and the changes already made to policy and practice locally are shared with Safeguarding Children Partnerships across England.

**Recommendation 1**

*That Barnsley Safeguarding Children Partnership share the learning from this LCSPR and the changes already made to policy and practice as a result of the death of child W with Safeguarding Children Partnerships in England.*

**'Early Warning' Systems**

**7.4** There was little doubt that the parents of child W could present a significant risk of harm to any child conceived by mother. None of their children are in their care and they had previously attempted to conceal pregnancies from the authorities in order to prevent the removal of children. Despite this, the agencies which initially became aware of mother's pregnancy with child W – mother's GP practice, the Out of Hours GP service and the epilepsy service – did not alert either children's social care or the police. The years which had elapsed since the most recent attempt to conceal a pregnancy and the belief that mother intended to terminate her pregnancy with child W were mitigating factors. Additionally, the police became aware of an earlier pregnancy, which is assumed not to have progressed to full term and did not appear to appreciate the significance of this.

**7.5** Mother and father remain a potential risk to any children they conceive – in this relationship or possibly in any other intimate relationship they may initiate. The risk they present to children should be clearly flagged up on the records of all agencies they are in contact with or may come into contact with locally and should either or both of them relocate, then the risk information should be shared with the area to which they move.

**7.6** It is therefore recommended that the Safeguarding Children Partnership obtain assurance that all relevant local agencies are made aware of the risk which mother and father present to any children they may conceive and that this information is conspicuously flagged on their records together with advice on action to take should they become aware of mother becoming pregnant.

**Recommendation 2**

*That Barnsley Safeguarding Children Partnership obtains assurance that all relevant local agencies are made aware of the risk which mother and father present to any children they may conceive and that this information is conspicuously flagged on their records together with advice on action to take should they become aware of any further pregnancy.*

**The role of GP practices in pre-birth planning**

**7.7** Barnsley's Pre-Birth procedures state that the antenatal period provides a window of opportunity for practitioners and families to work together to understand the impact of risk to the unborn baby (3). In this case the GP practice could have considered a safeguarding referral or a conversation with children's social care when doubts began to emerge about mother's intention to terminate her pregnancy with child W from 19th December 2019. This would have expanded the period available to partner agencies to work together to safeguard the unborn child W from 13 to 21 weeks.

**7.8** The GP practice also held much relevant information about mother's long-term use of morphine, concerns about dependency and drug seeking behaviour. This information was only partially shared as part of pre-birth planning. The GP practice was not involved in the one multi-agency meeting which took place.

**7.9** It is therefore recommended that the Safeguarding Children Partnership obtain assurance that GP practices play an appropriate part in pre-birth planning and as a minimum, are either invited to attend or send a report to any multi-agency pre-birth planning meetings.

**Recommendation 3**

*That Barnsley Safeguarding Children Partnership obtains assurance that GP practices play an appropriate part in pre-birth planning and as a minimum, are either invited to attend or send a report to any multi-agency pre-birth planning meetings.*

**Parental substance use and co-sleeping**

**7.10** There were an unusually large number of risk factors present in this case. However, the risk which led directly to the death of child W – mother's morphine use/possible dependence and drug seeking behaviour - did not receive sufficient attention, was never fully articulated and was insufficiently explored.

**7.11** This is the first of two local deaths of infants in quick succession in which the substance use of the mother increased the risk of sudden infant death arising from co-sleeping but where the risks to the child arising from maternal substance use had been under-estimated and insufficiently explored by professionals. This review has been advised that work on raising professional awareness of the risks arising from unsafe sleeping commenced in 2020, when a task and finish group was established led by Public Health. Key actions included undertaking a local review of cases and identifying learning themes from the local review and the national thematic review. Multi-agency training has been established and single agency training has been promoted. This is available as a virtual offer or e learning package. Multi-agency guidance is currently being developed which will include a risk assessment tool. Pathways for transfer of care and the highlighting of risks are under development. Work is underway to improve the postnatal offer around smoking cessation support. A public heath campaign is being run periodically through the year which includes a radio and social media campaign and promotional activities. Engagement of all agencies which have contact with children and families has been key to progressing this work and widening the scope from the traditional workforce (health visiting and maternity). Training has been delivered to social care staff and is now included as part of their risk assessment. In addition, a task group has been established to lead work on the **ICON** (**I** – Infant crying is normal; **C** –Comforting methods can help; **O** – It's OK to walk away; **N** –

Never, ever shake a baby) programme which was introduced in January 2021. This has included multiagency training, pathways and again awareness raising via social media and a radio campaign.

**7.12** It is therefore recommended that the Safeguarding Children Partnership monitors the effectiveness of the considerable action taken to increase professional awareness of the risks from co-sleeping, in particular the increase in the risk of sudden infant death from co-sleeping arising from substance use by parents or carers.

**Recommendation 4**

*That Barnsley Safeguarding Children Partnership monitors the effectiveness of the action taken to increase professional awareness of the risks from co-sleeping, in particular the increase in the risk of death to children from co-sleeping arising from substance use by parents or carers.*

**Safe Sleeping assessment**

**7.13** There is no indication that mother's use of painkillers including morphine and her drug seeking behaviour informed any safe sleeping risk assessment for the period in which mother would be caring for child W in hospital. Indeed, there is no indication that a safe sleeping risk assessment was carried out. It seems likely that a safe sleeping assessment was not considered because it was anticipated that child W would be in the care of mother for only a short period (3-5 days) and this brief period of maternal care would take place within the maternity ward of a hospital where mother and baby would be regularly observed and cared for by medical professionals. Despite the fact that many of the factors known to increase risk of sudden unexpected death in infancy from co-sleeping would not be present in a maternity ward environment, it would have been of benefit to carry out a safe sleeping assessment in this case.

**7.14** It is therefore recommended that the Safeguarding Children Partnership seeks assurance from the Barnsley Hospital NHS Foundation Trust that they will consider conducting a safe sleeping assessment when appropriate. It is accepted that this is only likely to be necessary for a small minority of hospital births.

**Recommendation 5**

*That Barnsley Safeguarding Children Partnership seeks assurance from the Barnsley Hospital NHS Foundation Trust that they will consider conducting a safe sleeping assessment when appropriate.*

**Assessment of risk of significant harm to the unborn child**

**7.15** In the case of child W, the risks arising from maternal substance use were overshadowed by other risks mother and father may present to child W. Clarifying risks was made more challenging by the limited engagement of mother and father in the pre-birth assessment.

**7.16** There is much to be learned from this complex case about clarifying risks, seeking out further information about risks where it is available and being really clear about the action necessary to mitigate risks. It would therefore be of value when the learning from this case is disseminated for approaches to assessing and managing risk to be highlighted.

**Recommendation 6**

*When Barnsley Safeguarding Children Partnership disseminates the learning from this case, approaches to assessing and managing risk are highlighted.*

**Multi-Agency Working in the Pre-Birth Period**

**7.17** Barnsley's Pre-Birth Procedures – which appear to have been revised to reflect the early learning from this case - and the Integrated Care Pathway for Pre-Birth Assessments (April 2020) set out in detail the process to be followed when there are concerns that an unborn child may be likely to suffer significant harm. The procedures and the pathway also set out at which stage of the pregnancy specific actions should be taken.

**7.18** However, the case of child W did not fit neatly into any pathway or procedures. Timescales were compressed and then tightened further and it was clear from the parent's current and historic behaviour that they were highly unlikely to co-operate with partner agencies and may attempt to obstruct or mislead them.

**7.19** Only one multi-agency meeting took place, which was the strategy discussion on 30th April 2020. This meeting could have been held much earlier which would have allowed more time for a subsequent Pre-Birth Conference and/or a Pre-Birth Planning meeting as envisaged by Barnsley's Pre-Birth Procedures. This would have been of great value in this case as, whilst the strategy meeting was a very helpful forum for sharing the large number of concerns in this case, it needed to be followed up by at least one further multi-agency meeting to ensure that the wide range of concerns had been translated into a clear plan with contingencies.

**7.20** Whilst it is important for the Safeguarding Partners to obtain assurance that the Pre-Birth Procedures and the Integrated Care Pathway are well understood and followed by professionals, this case also highlights the importance of having the ability to apply the principles of the Procedures and the Pathway to cases where greater urgency is required, and/or where the case is particularly complex or presents unusual features or risks.

**Recommendation 7**

*That Barnsley Safeguarding Children Partnership obtains assurance that the Pre-Birth Procedures and the Integrated Care Pathway for Pre-Birth Assessments are well understood and followed by professionals.*

**Recommendations 8**

*That Barnsley Safeguarding Children Partnership requests partner agencies to reflect on the particular challenges of this case and articulate how the principles of the Pre-Birth Procedures and Integrated Care Pathway could have been applied flexibly in order to safeguard child W from the risk of significant harm.*

**Birth Plans – defining supervision required by hospital**

**7.21** The Birth Plan did not define the level of supervision required for mother and child W whilst in hospital following the birth. This remains an important issue despite the amended practice of providing 1:1 support to mothers and new born children it is intended to remove.

The Integrated Care Pathway for Pre-Birth Assessments does not make explicit the importance of defining the level of supervision required and so it is recommended that the Pathway document is amended accordingly and that professionals are reminded of the need to define the level of supervision required. (BHNFT advise that since this incident they have a developed a policy which sets out responsibilities with regards to the supervision of children and parents, which has been shared with partner agencies).

**Recommendation 9**

*That Barnsley Safeguarding Children Partnership arranges for the Integrated Care Pathway for Pre-Birth Assessments document to be amended to make the need to define the level of supervision required explicit and that professionals are reminded of the importance of defining the level of supervision required.*

In addition, BHNFT propose the adoption of a memorandum of understanding stating which agency will be responsible for the provision of supervision. Since this incident the Trust have a developed a policy which has been shared with other agencies setting out responsibilities with regards to the supervision of children and parents.

**Mother's contact with father and others whilst in hospital**

**7.22** Father's absence from the hospital ward – primarily because of Covid 19 restrictions- largely removed the risks he could present to mother and child W from further consideration by professionals. The risk that he could continue to exert influence, possibly through coercion or control, over mother remotely or through in-person contact when she was absent from the ward was overlooked. Additionally, mother was frequently absent from the ward, including the occasion on which she was able to obtain a prescription of morphine from her GP. Whilst the hospital had no power to prevent mother leaving the ward, insufficient weight was given to the long history of manipulative and dishonest behaviour displayed by mother and father towards professionals. However, 'Dishonesty' and 'lack of meaningful engagement with services' were documented as concerns in the Birth Plan.

**7.23** In their contribution to this review, mother's GP practice has advised that patients attending in nightwear is not unusual. Reception staff knew mother well because of her aggressive behaviour when her previous attempts to obtain prescriptions early were declined and recalled her attendance on the morning after giving birth to child W. However, they did not notice any indication that mother was a hospital patient. The GP practice has conducted a 'significant event analysis' which decided that if a patient attends in nightwear, reception staff are to:

- visually check for hospital wristbands
- enquire of the patient if they are an inpatient at the hospital
- contact admissions desk at the hospital to directly enquire if the person has been admitted to hospital
- record ALL unusual occurrences in the medical notes
- inform the lead on-call GP of any 'unusual events'

**7.24** Mother's GP practice also stated that reception staff may not have considered the possibility that mother was a hospital inpatient because 'primary care has every confidence that hospital systems would prevent an in-patient from leaving an obstetric ward in her nightwear after giving birth'. This level of confidence is misplaced as hospitals can only prevent a patient leaving the hospital in very specific circumstances.

**7.25** There does not appear to be an obvious 'systems' solution to the administration of morphine by both the GP practice and the hospital in this case. However, it would be of value for the learning from this review, including the actions taken by mother's GP practice following their 'significant event analysis' to be circulated to all Barnsley GP practices and it is therefore recommended that the Safeguarding Children Partnership ensures that this is done.

**Recommendation 10**

*That Barnsley Safeguarding Children Partnership requests NHS Barnsley Clinical Commissioning Group to ensure that the learning from this case, including the measures taken by mother's GP practice, are disseminated to all GP practices in Barnsley.*

**7.26** The outcome of the criminal investigation is ongoing which is examining contact between mother and father following the birth of child W in detail. Further learning for the hospital may emerge once the criminal investigation is completed and so it is recommended that the Safeguarding Children Partnership requests South Yorkshire Police to advise them of any further learning when the criminal proceedings are completed.

**Recommendation 11**

*That Barnsley Safeguarding Children Partnership requests that South Yorkshire Police advise them of any further learning from this case arising from the criminal investigation.*

**Antenatal visits by health visitor**

**7.27** It is worthy of note that this is the third Barnsley CSPR completed by this independent reviewer in which the parents did not receive the nationally mandated antenatal health visitor visit, including two cases in which very young babies have died. Whilst it was clear that child W was to be removed at birth, partner agencies had agreed that all scheduled interventions should be completed.

**7.28** It is therefore recommended that the Safeguarding Children Partnership seeks further assurance that the 0-19 service has systems in place to ensure that antenatal visits are conducted.

**Recommendation 12**

*That Barnsley Safeguarding Children Partnership obtains further assurance that the 0-19 service has systems in place to ensure that antenatal visits are conducted.*

**Antenatal and postnatal risk of maternal epilepsy**

**7.29** It is clear that there were considerable antenatal risks to mother and child W arising from mother's epilepsy and her risk of seizures arising from the management of her condition. In their contribution to this CSPR, BHNFT has advised that, given these antenatal risks and increased risk to mothers and infants in the postnatal period (4) there is a requirement for better risk assessment for all expectant mothers with epilepsy and a multi-disciplinary plan for the birth. SWYPFT has advised this review that currently, the epilepsy specialist nurse offers a face to face appointment with the pregnant woman to go through a checklist and risk assessment in relation to their pregnancy and treatment. This is done in

liaison with the epilepsy midwife, who also monitors the pregnancy. The pregnant woman also receives written information in relation to epilepsy and the management of epilepsy. SWYPFT add that historically, there was an epilepsy specialist midwife in the hospital and there would be a joint clinic for women to attend. This service was discontinued due to staffing and resource issues.

**7.30** It is therefore recommended that the Safeguarding Children Partnership seek assurance from BHNFT and SWYPFT in respect of improvements made to risk assessment and pre-birth planning for expectant mothers with epilepsy.

**Recommendation 13**

*That Barnsley Safeguarding Children Partnership seeks assurance from BHNFT and SWYPFT in respect of improvements made to risk assessment and pre-birth planning for expectant mothers with epilepsy.*

**Safety of professionals**

**7.31** Both the midwife and the social worker made unaccompanied home visits to mother and father without the knowledge that father could present a risk to them until information was shared at the strategy meeting that there was a police warning about him carrying weapons. Additionally, the GP practice had utilised an alert after feeling threatened by mother and father earlier in the pregnancy with child W. There is no indication that this information about risk to professionals was shared as part of multi-agency pre-birth planning.

**7.32** In this particular case the risk to professionals could be included in the 'early warning' information which it is recommended should be recorded by partner agencies (Recommendation 2). However, the late sharing of information about risk to professionals may also apply to other cases.

**7.33** It is therefore recommended that the police work with those partner agencies which may make home visits in advance of full information sharing - such as children's social care, midwifery and health visiting - in an effort to devise an approach to earlier information sharing about risks to professionals, particularly when lone working.

**Recommendation 14**

*That Barnsley Safeguarding Children Partnership requests South Yorkshire Police to work with those partner agencies which may make home visits in advance of full information sharing - such as children's social care, midwifery and health visiting - in an effort to devise an approach to earlier information sharing about risks to professionals, particularly when lone working.*

**The National Panel's SUDI Review**

**7.34** Whilst the case of child W has many of the features of the cases considered by the SUDI review, the key difference is that the child's death arose as a result of co-sleeping with her mother in an environment which would not normally be considered unsafe i.e. on a maternity ward whilst being monitored closely by maternity staff than would normally be the case.

**7.35** The SUDI review arrived at the following three conclusions:

- Professionals needed to obtain a better understanding of parental perspectives in order to develop a supportive yet challenging relationship which facilitates more effective safer sleep conversations.
- Work to reduce SUDI needs to be embedded in multi-agency working and not just seen as the responsibility of health professionals.
- The use of behavioural insights and models of behaviour change to support interventions to promote safe sleeping need to be explored.

**7.36** Applying these conclusions to the case of child W, mother and father's marked reluctance to engage with professionals severely limited an understanding of their perspective, which could not be taken at face value in any event. This case also indicates that there is further work to be done to embed work to reduce SUDI in multi-agency working. Mother did not receive safe sleeping advice from the social worker who conducted the pre-birth assessment, although this review has been advised that social workers now routinely speak to mothers about safe sleeping and this is recorded on case files. Achieving behaviour change was not a professional focus in this case given the decision to remove child W from the care of her parents.

**References:**

(1) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/464880/Universal_health_visitor_reviews_toolkit.pdf

(2) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

(3) Retrieved from https://www.proceduresonline.com/barnsley/scb/p_pre_birth.html

(4) Retrieved from https://epilepsysociety.org.uk/pregnancy-and-parenting

## Appendix A

### Process by which the CSPR was conducted

It was decided to adopt a broadly systems approach to conducting this CSPR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Agency reports and chronologies which described and analysed relevant contacts with child W and her family were completed by the following agencies:

- Barnsley Children's Services

- Barnsley Clinical Commissioning Group
- Barnsley Hospital NHS Foundation Trust (BHNFT)
- Barnsley Public Health Nursing Service
- South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)
- South Yorkshire Police

The independent reviewer analysed the chronologies and identified issues to explore with practitioners and managers at a learning event facilitated by the independent reviewer.

At the time of writing it had not been possible to offer child W's family the opportunity to contribute to the review as a result of the ongoing criminal investigation into the circumstances of child W's death.

The independent reviewer then developed a draft report to reflect the agency reports, chronologies and the contributions of practitioners and managers who attended the learning event. The report was further developed into a final version and presented to Barnsley Safeguarding Children Partnership.