Each Baby Counts – RCOG Six Month Progress Report

The Department for Education has published statistics on child death reviews completed in England between 1 April 2014 and 31 March 2015. Findings include 3,515 reviews were completed by Child Death Overview Panels in the year ending 31 March 2015, of which 24% were identified as having modifiable factors.

According to statistics released today by the Office of National Statistics (ONS), there were 249 unexplained infant deaths in England and Wales.

- The rate of unexplained infant deaths rose to 0.36 per 1000 live births, up from 0.32 deaths per 1,000 in 2012.
- The rate of infant deaths for mothers aged under 20 rose significantly from 0.92 to 1.27, four times greater than babies born to mothers aged 20 and over.
- The North East and North West of England were the worst affected - the rate of unexplained infant deaths rose to 0.41 and 0.45 in those regions respectively. Wales also experienced an increase to 0.53 deaths per 1,000.

A review that will look at how new born babies with deteriorating health are cared for by hospitals and in the community has been announced today.

The Care Quality Commission (CQC) will look at current practices for managing new born infants with significant health problems in around 20 neonatal services offering different levels of care in England. The inspections are due to start in September (to publish end March 2016).

During the review, the regulator will look at how well fetal medicine, obstetrics, neonatal and community services work together to care for new born babies with declining health problems.

The thematic review of neonatal services will look at current practice in relation to the management of new born infants whose health is deteriorating, with particular focus on the diagnosis and management of hypertension (high blood pressure), the management of respiratory support technologies (including tracheostomies) and how well the services work together to identify and follow up on any complications during pregnancy........

The review could lead to the development of national clinical guidelines by professional bodies........

The ChildLine annual review reveals that after suffering abuse, many children are unable to access the support services they need. Every 6 minutes a child is counselled by ChildLine about mental health-related concerns. The 2014/15 ChildLine annual review, ‘Always There When I Need You’, also highlights that 1 in 10 contacts is about abuse....
The top 3 concerns counselled were family relationships, low self-esteem/unhappiness and abuse. 4 of the top 10 issues related to mental health. These issues were self-harm, suicide, low self-esteem/unhappiness and mental health conditions, together they accounted for almost one third of total concerns.

One in four local authorities are failing to adequately assess and monitor the mental health needs of looked-after children, a study by the NSPCC has found.

A new resource has been published to assist local organisations in preventing linked suicides, also known as “suicide clusters”, in their areas. Launched by Public Health England, the toolkit will support local authorities in their reaction to an unexpectedly high number of suicides occurring in a particular place, period of time or both.

This document is intended to support local authorities to put advance plans in place to analyse the situation quickly, and prepare a coherent, measured and co-ordinated response. It should be read alongside Public Health England’s guidance for developing a local suicide action plan.

A 14-month-old baby was found hanged in her cot after her pyjamas became attached to a hook on her cot..... The court heard that her mother put her daughter to bed on the afternoon of April 17, checking on her every hour until 3pm when she found her on the hook.....A coroner has ruled her death a ‘tragic accident’.

Mum and dad had bought the hooks and cot from Ikea which has said it will add new warning signs to its cots ‘over and above’ British standards....The statement will warn buyers not to “attach, stick, or add any item to the inside or outside of your cot, it may became a catch hazard for your baby.”........

Doctors are calling for beefed up warning labels on alcohol-based hand sanitiser after a three-year-old Australian girl was poisoned by the potentially-deadly substance. The toddler was brought to Melbourne’s Royal Children's Hospital suffering from abnormally low blood pressure and an “altered level of consciousness”. She was diagnosed with acute alcohol poisoning.

Doctors calculated that the 16kg toddler drank at least 55ml of the hand sanitiser, which was 70 per cent alcohol......

The authors linked the girl's case with the increasing reports of teenagers deliberately drinking hand sanitisers that are up to 95 per cent alcohol.

In the hands of children, alcohol-based hand sanitiser was a “potentially fatal toy”, they warned......

On 1 June, new standards came into force to reduce the risk to children from being poisoned and burned by liquitabs. New European Union (EU) rules governing the safety of liquitabs – laundry detergent capsules – and their packaging came into effect on 1 June. The regulations require that liquitabs sold in the EU:
- take more than six seconds to dissolve
- have a coating that is impregnated with a bittering agent
- are packaged in non-transparent boxes
- are packaged in boxes that are printed with warnings and have a child-resistant closing mechanism

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**Children & Young People Now article**

**NSPCC report: Achieving emotional wellbeing for looked after children**

**Practice resource - Identifying and responding to suicide clusters**

**News article**

**Telegraph article**

**CAPT safety news**
Manufacturers have been given 6 months to comply with the new regulations, so it won’t be until the end of this year that consumers will notice the new packaging on the shelves of supermarkets.

Antenatal substance misuse and smoking and newborn hypoxic challenge response

Abstract
Objectives Infants of smoking (S) and substance misusing (SM) mothers have an increased risk of sudden infant death syndrome. The aim of this study was to test the hypothesis that infants of SM or S mothers compared with infants of non-SM, non-smoking mothers (controls) would have a poorer ventilatory response to hypoxia, which was particularly marked in the SM infants.

Design Physiological study.
Setting Tertiary perinatal centre.

Patients 21 SM; 21 S and 19 control infants. Infants were assessed before maternity/neonatal unit discharge.

Interventions Maternal and infant urine samples were tested for cotinine, cannabinoids, opiates, amphetamines, methadone, cocaine and benzodiazepines

Main outcome measures During quiet sleep, the infants were switched from breathing room air to 15% oxygen and changes in minute volume were assessed

Results The SM infants had a greater mean increase (p=0.028, p=0.034, respectively) and a greater magnitude of decline (p<0.001, p=0.018, respectively) in minute volume than the S infants and the controls. The rate of decline in minute volume was greater in the SM infants (p=0.008) and the S infants (p=0.011) compared with the controls.

Conclusions Antenatal substance misuse and smoking affect the infant's ventilatory response to a hypoxic challenge.

PUBLISHED SERIOUS CASE REVIEWS (JUNE-AUGUST 2015)

August 2015 - Death of a 5-month-old baby in September 2014. Child F was found unresponsive by mother after mother and baby had fallen asleep on a sofa when staying overnight at mother's friend's home. Ambulance crew noticed the smell of alcohol on mother and called police. Mother was arrested on suspicion of neglect, having thought to have unintentionally rolled on top of her baby; criminal investigation concluded with no charges being preferred.

Background: little is known about child F's father, beyond his extensive criminal history. Mother entered local authority care when 10-years-old, where she remained until discharge at age 18. Maternal history of: chronic neglect; disrupted placements; significant alcohol and drug misuse; domestic abuse; and offending.

Learning: identifies emerging lessons and reflections, including: the consequences of adverse childhood experiences such as chronic neglect and the inclination of individuals to deny or diminish these experiences; workload, difficulty in collating information or anxiety about challenging service users inhibiting professional recognition or exploration of patterns of behaviour such as missed appointments; invisibility of men; and obstacles to information sharing.
July 2015 – Death of a 6-7-week-old-girl in May 2012. Subject child was found by mother with her face pressed up against the back of the settee at home where she had earlier fallen asleep. Mother had just woken from sleep after having drunk alcohol earlier in the day.

**Background:** mother was arrested in 2011 for being drunk in charge of a child, leading to half-brother being placed in foster care. Half-brother was returned to mother’s care following assessments that recommended that there was no role for a social worker. Mother has a chronic abdominal condition, requiring abstinence from alcohol use to avoid the condition worsening and leading to hospitalisation.

**Key issues:** history of domestic abuse, alcohol misuse and referrals to children’s services concerning the care of half-brother.

**Learning:** assessment of the impact of chronic alcohol misuse usually takes place when the parent is no longer intoxicated, leading to insufficient understanding of potential risks to the child; lack of professional knowledge of parents’ persistent or long term medical conditions compromising understanding of the impact on parenting capacity; and professional response to incidents without consideration of previous concerns, leading to missed patterns and possibility of continued ineffective responses.

August 2015 – Stockton-on-Tees - **Serious harm caused to a 12-year-old, identified in July 2013 when serious concerns were raised over poor home environment and Child H’s presentation, including impaired vision. Child H was taken into the care of the local authority and mother and mother’s partner were charged and sentenced to 30-months imprisonment for child cruelty.**

**Background:** Child H was diagnosed with Juvenile Idiopathic Arthritis (JIA) when 5-years-old. JIA can lead to eye problems, which, if not detected and treated early, can cause permanent visual damage, including blindness. Child H was found to have early indicators of uveitis at an ophthalmology appointment in 2011; Child H did not attend any further ophthalmology appointments until July 2013. Children’s social care received three referrals between 2011 and 2013 and concerns had been raised regarding Child H’s presentation, hygiene and attendance at school and medical appointments.

**Key issues:** the system for screening children with complex eye problems is not designed around the needs of the child: the appointment system implied Child H was making informed choices about not attending, rather than parents’ non-attendance being seen as an indicator of neglect.

**Learning:** children with medical needs necessitating a range of specialists, require a lead professional to maintain coordination of services, in particular, the role of the school nurse should be developed to engage with children and parents and to assist schools in understanding the impact of specific conditions.

July 2015 – Peterborough – **Significant, non-accidental injuries to a 5-month-old boy, identified in November 2013; injuries were diagnosed as suggestive of physical and sexual abuse. Father was charged with neglect, to which he admitted and received a community sentence; he denied and was not charged with sexually abusing child J.**

**Background:** Child J’s mother had two older children, both of whom were living in foster care at the time of child J’s birth; Child J was discharged from hospital to foster care when 2-days-old before being placed in the full-time care of his father when 4-months-old.
Key issues: paternal history of: depression; committing domestic abuse; offending with minor convictions; drug and alcohol use; and allegations of inappropriate sexual behaviour. A number of injuries were identified by various professionals in the month prior to the incident.

Learning: identifies themes, including: optimistic thinking driving plans for Child J to be placed with his father to the exclusion of thorough exploration of risk; insufficient information sharing between agencies; and lack of holistic assessment of family leading to unacceptable evaluation of risk.

Recommendations: makes various recommendations including monitoring the use of escalation procedures.

July 2015 – St Helens – Death of a 17-year-old-10-month-old boy found hanged at home in January 2014. Inquest found that Child JSH had intentionally taken his own life.

Background: history of: domestic abuse; anti-social behaviour; violent behaviour leading to arrests; sexually intimidating behaviour toward members of school staff and female pupils; and stalking and threatening behaviour toward a fellow pupil with whom child JSH had a relationship. Child JSH was described as having had few close friends but a wide network of associates on social media and a high-profile locally in relation to fighting and anti-social behaviour. Police had intelligence that child JSH was receiving threats via social media 2-3-weeks prior to his death.

Learning: identifies four key findings, including: remaining child-centred in responses to older children who present with criminal and harmful sexual behaviours (HSB); and meeting the needs of children who experience severe behavioural difficulties through the system of mental health referral and triage. Identifies wider learning around: the risks presented by social media in relation to developing networks that promote and encourage HSB.

June 2015 – Cambridgeshire – Death of a 2-year-old boy in January 2014. Primary cause of death was bacterial pneumonia infection with secondary causes of dehydration, failure to thrive, norovirus and cerebral palsy.

Background: following his death, mother received a police caution for cruelty against Child K contrary to Section 1 of the Children and Young Person’s Act 1933. Child K and his sibling had been subject to a child protection plan for neglect for a month prior to the incident.

Key issues: maternal history of: childhood abuse, time spent in the care of the local authority, offending, self harm and homelessness. Father was nine years older than mother and also had a history of childhood abuse and time spent in the care of the local authority. Child K was born 24-weeks prematurely, which affected his lung development causing chronic lung disease. Child K had additional complex needs resulting from a hole in his heart, concerns about his hearing and vision and a bleed in his brain resulting in him developing cerebral palsy.

Learning: analyses key themes, including: the impact of Child K’s disabilities on assessment of risk and inconsistency in the level of professional concern; inconsistent perceptions of mother’s understanding of Child K’s needs or of her ability and commitment to meeting them; and lack of professional understanding of the interaction between Early Help, Early Support and Children in Need systems.

**Background:** Child B moved to the UK aged 6 to live with his father and older brother; contact with their mother was sporadic. Child B was made the subject of a child protection plan, when 10-years-old, for physical and emotional abuse and was briefly looked after. From 2012 the family were receiving support after the father had an accident at work and they became homeless. On the day he killed himself Child B spoke of wanting to take his own life.

**Learning:** Child B's voice and experience were not present in any reviews; limited exploration of the impact of mother's absence; and copy and pasting of old information into new reports.

**Learning from case reviews** - NSPCC thematic briefings - each one focuses on a different topic, pulling together key risk factors and practice recommendations to help practitioners understand and act upon the learning from case reviews.