Plymouth Safeguarding Children Partnership: Learning on a Page Baby Isla

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Baby Isla's Lived Experience

Isla was born in July 2020 with a low birth weight. She stayed in hospital due to neo natal abstinence syndrome (opiate withdrawal) because of her mother's prescribed medication history. Fortunately, she didn't need any treatment for opiate withdrawal and went home with her parents Karen and Colin. Isla had 3 siblings, a brother Daniel and sisters Elizabeth and Susan.

Karen had a complex physical and mental health history that involved historic drug use. Karen was prescribed opiate-based medication for pain relief and anxiety and used cannabis daily to aid pain relief, alongside smoking tobacco. Colin had one previous mental health episode with no other incidents noted.

The family were known to children's social care (Children's Disability Team) and received support on a child in need plan to help with Daniel's complex needs. Daniel's needs included autism and severe learning difficulties. During 2017 to 2018 children's social care carried out single assessments following concerns about Karen's cannabis use, Daniel's developmental delay, dental decay and lack of parental supervision. This led to early help interventions with no further involvement by children's social care at that time.

In March 2020, Covid restrictions came into place and the family shielded due to Karen's vulnerability. Children's social care introduced a RAG (red, amber or green) rating to understand and respond to need and risk. Daniel was rated green meaning visits took place virtually. Once Isla was born, the midwife and health visitor continued with home visiting inside the family address with no safeguarding concerns raised. It was felt Karen and Colin were engaging well with support

On the morning of the 18th September 2020, Isla was found by her father, at their home address, unresponsive in the arms of her sleeping mother. Karen slept downstairs in the dining room in a single leather seat next to Isla's travel cot. An ambulance was called and Isla was taken to the emergency department. Sadly, Isla was found to have already passed away on arrival at the emergency department.

Police and ambulance clinicians attended the family home on the day of Isla's death. They raised significant concerns about Isla's sleeping arrangement. Isla's travel cot was cluttered and showed no signs of her having been able to sleep in it. Karen and Colin challenged this and they reported the clutter was caused by the panic that followed when Isla was found unresponsive. Agencies attending that day were also concerned about the neglectful condition of the home, Karen's complex needs, medical history and substance misuse.

Following a full post mortem, it was established that neither drugs nor alcohol played a part in Isla's death. The pathologist reported her death would not fulfil the criteria for sudden infant death syndrome (SIDS). The cause of Isla's death was therefore unascertained.

What we Learned From Baby Isla

Parental Drug Misuse: Agencies acknowledged that Karen's pregnancy with Isla was high risk because of Karen's prescribed medication, cannabis use and long-term health conditions However, the complexity of the situation did not raise safegaurding concerns with Karen's cannabis use not considered problematic in the context of its prevalent use within the community. Subsequently no multi-agency pre-birth assessment was completed.

Neglect: Isla's home was in an area of Plymouth with high levels of social deprivation with professionals describing the house as 'poor housing.' Professionals can become desensitised to neglect particularly when working in areas of high multiple deprivation.

Indicators of neglect for the family date back to 2017 but support focused on ensuring practical support for Daniel. This focus meant that the wider multi-agency network was not sufficiently alert to what may be contributing to neglect within the declining family environment, and the children's lived experience.

Assessments: Daniel was the only child in the family open to children's social care. The family declined further assessments for the other children leading to the focus being on Karen and Daniel's needs. A strengths based, restorative conversation with them could have better informed their decision on consent. A wider whole family approach could have supported a greater understanding and inclusion of Colin as the main carer for Isla and strengthen male inclusive practice.

Safer Sleep: A wealth of information was given to the family about safe sleeping, including the risks of co-sleeping. The family reported that Isla slept in a cot upstairs in a bedroom.

Isla actually slept in a travel cot, downstairs in the dining room with Karen sleeping in a chair next to the cot. Isla's sleeping arrangements were not physically seen by any professional. Those visiting the family home were shown into the lounge and did not have sight of the rest of the house.

Police photographs taken on the day of Isla's death show the ground floor kitchen/dining room where Isla slept, and upstairs bedrooms were significantly cluttered, chaotic and at best only partially fit for their purpose.

Impact of Covid: The Covid pandemic posed significant challenges for families, services and professionals and this should not be underestimated. As mentioned Daniel was rated as green by children's social care meaning visits took place virtually. Isla's birth did not trigger a review of the rag rating to reassess the needs and vulnerability for the family and children. Health professionals were unaware that social workers were not physically visiting the home representing a gap in communication and risk management during a time of heightened vulnerability for the family.

Learning into Practice for Baby Isla

Think family: 'Thinking family' rather than focussing on the needs of individual children can help gather a better picture of family patterns, issues, strengths and risks. Ask yourself:

- Do I fully understand all of the children's needs and how this influences family life and parenting?
- Have I overly focused on one child? If so, why is that?
- Have I genuinely engaged with and included male carers?

Reflect on social norms and desensitisation:

Sometimes when we are so used to supporting families or communities with high levels of need or particular ways of being and behaviour we can become desensitised to indicators of risk. This can include levels of neglect and drug use.

If you find yourself thinking or saying, 'that's usual', just stop, step out of that thought for a moment and reflect… is it? It may well be usual, but has that also meant you've not seen the risk in a particular situation.

Be curious: Professional curiosity helps keep children safe.

Exploring situations, asking open respectful questions, following up information, not taking things at face value and checking the accuracy of information is essential. This is particularly important when supporting families with a range of needs and where there is a number of agencies involved. Are all agencies clear of what each other is doing/not doing?

Safer sleep is everyone's business: We can all promote the safer sleep message and ask where and how babies are put to sleep. But, it's more than knowing and sharing the message. It's also about understanding if families are following advice, what the barriers are and reassessing risk. Remember safer sleep advice should be shared with everyone that cares for a baby e.g. mother's, father's and grandparents.

Where appropriate it's also OK to ask to see where a baby sleeps so you can support the family with the right advice and response. So, get to know the safer sleep message which is by The Lullaby Trust.

Follow them on Twitter/Facebook/Instagram to stay up to date. You could also suggest families do the same so they get all the latest safer sleep messages quickly and direct to their phone.