Sandwell Children's Safeguarding Partnership statement
NS Serious Case Review

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Lesley Hagger, Chair of Sandwell Children's Safeguarding Partnership and Executive Director of Children's Services in Sandwell, said: "Following a serious incident involving a child, we always undertake a full, thorough and detailed review to see what can be learned to help improve services. This process also ensures we share good practice in the support offered to families.

"This was a very sad case in which a two-month-old baby died while co-sleeping in their parents' bed.

"The independent review established there was 'no significant deficit in services' relating to this child, who is referred to as NS in the anonymised report. Practitioners had no concerns about NS's care prior to the death in 2019.

"The review highlighted areas of good practice in the support offered to families as well as some learning points with five recommendations which partner organisations are following up.

"This case is a reminder of the risks associated with co-sleeping with babies and young children. Advice was given about safe sleeping in this case, both in the antenatal and post-natal periods.

"Research shows that the risks of co-sleeping increase significantly if a parent or carer has consumed alcohol or drugs. Babies born prematurely are also more vulnerable.

"We are working with partner organisations across the West Midlands to raise greater awareness of the risks of co-sleeping, and this issue is also being reviewed by the National Safeguarding Panel following incidents around the country.

"Locally, NHS partners have recently released videos to raise awareness of the risks of co-sleeping while under the influence of alcohol.

"The Sandwell Unborn Baby Network has been developed following a recommendation from a previous serious case review, with work ongoing to ensure the network is able to identify and support families with vulnerable babies at the earliest point.

"The review recognised how all family members, including siblings, can be seriously affected by the stillbirth or neonatal death of a baby, with anxieties about any future

pregnancy. It also stressed the importance of ensuring that support should include fathers and siblings and not be tailored solely towards mothers.

“The family in this case spoke positively about the support they received at hospital around NS’s birth, noting that staff acknowledged a previous bereavement the family had experienced and placed ‘purple butterflies’ on NS’s record to signal that they had suffered a neonatal loss in the past.

“Work across health services and partner agencies is under way to make sure all professionals are able to sensitively support families who experience a stillbirth or neonatal loss.

“To address recommendations identified in the review, the Sandwell & West Birmingham Clinical Commissioning Group (CCG) has established a rolling programme of face-to-face safeguarding training specific to primary care which is available to all GP practices. This is based on case scenarios and includes learning from other serious case reviews.

“The CCG has also established a GP Forum – led by the CCG Named GP and Assistant Designated Nurse for GP Safeguarding Leads from all practices – as a vehicle for discussion and dissemination of learning from serious case reviews.

“As always, we are committed to learning from serious case reviews to make sure organisations continue improving support to families who need it.”