Billy Serious Case Review Briefing

Southampton Local Safeguarding Children Board

The Background

Billy's family lived together in a first floor three bedroom flat provided by Southampton City Council. Billy and his 5 older siblings all the same mother and father, Chloe and Luke. There is little obvious other family support. Both parents are unemployed and Chloe is a smoker. Both parents have a history with social care going back to their childhood and neither have any previous convictions. Billy was born eleven weeks premature by emergency caesarean due to maternal infection, and had a six week stay on the Neonatal Unit prior to discharge home. He was readmitted eleven days later with bronchiolitis and he was discharged after 3 weeks.

Safeguarding Concerns

There were risk factors present within the household including; a young family with six children under the age of seven years old, historical concern regarding neglect and abuse and two concealed pregnancies. Furthermore adults in the household were known to be smokers. It was evident through the review period that Chloe and Luke struggled in their parenting with many examples of poor supervision, verging on the dangerous, being seen and responded to by professionals. There was also significant neglect and possible non-accidental injuries observed, none of which were effectively resolved or sometimes even investigated. The lack of engagement by Chloe and Luke, both in respect of themselves and their children, whilst well known to most agencies, never sparked the curiosity that young parents, with a large young family and a number of well-known complex safeguarding and child protection concern should have. The failure to attend appointments and frequent cancellation of others should have triggered concerns but did not.

Billy died at the age of twenty-one weeks old whilst co-sleeping with his mother on a sofa. He had a short and turbulent life prior to that. Despite Chloe disputing this, she did not present as pregnant until she was twenty weeks pregnant.

The Incident

In February 2018 at Billy's father, Luke contacted South Central Ambulance Service when Billy was found to be unresponsive. Paramedics arrived at the scene and noted that Billy was supine on the floor unresponsive and floppy. Billy was immediately picked up and taken into the ambulance where CPR was ongoing during which. Paramedics did not note any further injuries. Billy was taken by ambulance to Southampton General Hospital and resuscitation was attempted at the hospital but Billy was pronounced deceased. It appeared that whilst sleeping on the sofa with Chloe, Billy had rolled into the frame of the sofa in the gap between the cushion and the back. Following investigation, there was nothing to indicate that the death was suspicious in nature.

The Review

Southampton LSCB commissioned Graham Bartlett, Independent Reviewer, to lead this review. This review is also referenced as part of wider thematic review of Co Sleeping in Southampton. Agencies involved with the family were asked to provide summary reports and chronologies. A facilitated practitioner's workshop and a panel meeting were convened to consider the findings and learning for the review. The reviewer also engaged with the family as part of the review process.

The Findings

1. It is not possible to say whether anything done differently would have prevented Billy from dying the way he did but, as this review has shown, there were numerous missed opportunities to provide his family with the appropriate levels of challenge and support.

2. They were well known to a range of agencies, all who saw the same things; a family who were reluctant or unable to engage with services in a meaningful way, who either did not hear or rejected clinical advice, whose home was becoming more challenging as each child was born, yet no one appreciated the added pressure this was bringing on already struggling parents.

3. Billy and Tommy (sibling) were premature and low birth-weight and, as a consequence had chronic health problems which could only have intensified the difficulties their parents faced. Much was said about the perceived lack of attachment shown to Billy, particularly when he was in hospital, but this might have been how young parents with five other children coped with their competing demands.

4. Despite the evident risk factors, no enhanced or targeted safe sleeping advice was provided over and above that given to lower risk families. Given the history of the parents struggling to follow advice around their own health, it is difficult to predict a different response to generic advice which did not emphasise their real risk of SIDS, which sadly came to fruition.

5. At the time the children social care function was known to be failing and, as a consequence, but not solely for that reason, so was the child protection system. Conferences and other child protection meetings were poorly attended and lacked rigour, step down decisions seemed to have been taken with no management oversight or 'plan B' and decisions around legal interventions faded away. A child protection investigation categorically failed due to an unfathomable failure of information sharing and partnership working.

6. Internal safeguarding processes were unreliable so too was information sharing both within and across sectors. This meant that no agency or partnership ever had the full picture of what life was like for the children and what could be done to improve it.

7. That said, many gaps and concerns highlighted through this review have already been identified by the agencies, the partnerships and the LSCB. Significant change has taken place within Children and Families Service, the health visiting service has a new layer supported by bespoke supervision, the acute trust has developed its safeguarding support for clinicians and primary care has introduced standards to ensure GP oversight of safeguarding.

Useful links for good practice

- Southampton LSCB Website – for Southampton/4LSCB procedures and protocols, training offer
- Southampton LSCB Neglect Strategy
- Southampton LSCB Neglect Practitioners Guide and Toolkit
- 4LSCB Neglect Protocol
- 4LSCB Procedures
- The Lullaby Trust Safe Sleep Advice
- Safer Sleep: Saving Babies Lives – a professional guide
- NSPCC Case Review Summary – Working with parents of children under 2 yrs
- NSPCC Case Review Summary – Disguised Compliance
- Working Together 2018
- The Family Approach Toolkit