Reece Serious Case Review Briefing

Southampton Local Safeguarding Children Board LSCB

The Background

Reece was living in tenancy supported accommodation with Beth, his mother, his half-brother Ollie, and Beth's partner Callum. Beth's demographic, and the possibility of her and Callum smoking tobacco and cannabis near Reece, put Reece in a higher risk group for Sudden Infant Death Syndrome (SIDS). Beth told police that she, Ollie and Reece lived in a single room and that Callum stayed two or three nights a week. The adults slept on the airbed, Ollie had a toddler bed in the room and Reece a Moses basket, also in the room. Reece had been formula fed since birth.

Safeguarding Concerns

Beth was fourteen when she gave birth to Ollie (Reece's older half sibling), the pregnancy was unplanned. Two months prior to Ollie's birth she was stepped down from being a Child in Need and, pre-birth, Ollie was designated a Child in Need. There were enduring concerns regarding Beth putting her needs ahead of Ollie's, her ongoing fractious relationship with her mother – principally regarding her parenting role, the frequency of police calls, professionals observing a varying quality of parenting from Beth, the lack of stability in her housing arrangements and disengagement with services. Beth had previously been on the Child Protection Register (now referred to as being on a Child Protection Plan) under the category of neglect due to a longstanding history of domestic violence & domestic disputes between their parents and issues of parental mental ill-health. Initially, after Reece's birth, there were concerns about his feeding but these were resolved. At the last post-natal visit by maternity, Beth reported that her mood had improved since moving from her mother's house and that she remained unsure of Reece's paternity. Her good attachment was noted and safe sleeping was discussed with her. There was no suggestion that she adopted unsafe sleeping practices with Ollie.

The Incident

South Central Ambulance Service were called to an address in Southampton to a report that Reece, a non mobile baby under 3 months old, had been found unresponsive by his parents in his Moses basket. The ambulance report recorded that Reece was in cardiac arrest and the family were commencing CPR. When the ambulance arrived, the paramedics found that Reece was unresponsive. He and his mother were taken to Southampton General Hospital where, following unsuccessful CPR, he was pronounced dead. Information from Callum, comments from Ollie and evidence found in a search of the home, however, led police to suspect that Reece may have been sharing Beth and Callum's double air mattress on the floor. Beth denied that she was, or ever had, co slept with Reece. It is not possible to fully understand what the sleeping arrangements were on the night he died.

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.

Beth and her mother were interviewed for this review and both were supported by a friend and their Family Engagement Worker. It is worth highlighting that neither felt the system and the agencies within it were particularly supportive. This was their view, and others may not agree, but their experience of the system was, in their words, 'too focused on judging and not enough on supporting.'

The Findings

1. This review has not found any factor that would necessarily have prevented Reece's death and its cause was not ascertained; neither the post mortem nor the inquest could be conclusive. The evidence pointed towards co-sleeping but Beth said this was not the case.

2. The family were well known to a wide range of services and there was a genuine concern about them. However, their complexity and level of need stretched and tested the system.

3. There were few specific concerns over Reece during his short life but plenty regarding Ollie and Beth and individual agencies worked hard to mitigate these. However, Beth was rarely seen as a child with her own needs over being a parent or as a 'consensually sexually active' young woman.

4. Despite examples of good practice, the child protection system was not always responsive enough to emerging concerns that sometimes arose directly after step down. Beth said she did not feel supported through it. It also was undermined by fragmented information sometimes leading to over optimism and the full picture being missed.

5. The housing provision was not suited to young vulnerable families with complex and, sometimes, competing needs. On occasions an inappropriate criteria-based approach was taken rather than a needs-based one which could have helped Beth and her children settle more sustainably.

6. The period reviewed covered five years during which there have been three iterations of Working Together to Safeguarding Children and regulatory inspections have taken place across all agencies leading to huge change. The professionals who contributed to this review recognised the shortcomings and demonstrated a determination to improve services so that families such this are supported and provided for better in future.

Useful links for good practice

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