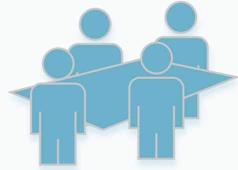
South Gloucestershire Children's Partnership
Practitioner Learning Brief
SCR: Toby March 2020

Background Summary

At about 10am on Sunday 14th January 2018 the parents of 5 week old Toby found him very pale and icy cold in his cot. An ambulance arrived soon after this and pronounced him dead. His father had last seen him alive at around midnight the night before. The family was spending the weekend at paternal grandmother's house where father lived.
Toby and his mother were known only to maternity services, GP and health visitor. No concerns had been raised about Toby or his parents prior to his death.



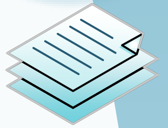
All 3 organisations Involved took part in the review

Toby's family were invited to take part in the review but chose not to

The Process

An independent reviewer was engaged. There was an agreed delay in progressing the review following a request from Avon & Somerset Police due to their criminal investigation. Understanding practice in context requires reviewers to engage those people who were directly involved in the case in a collaborative process of dialogue, as well as drawing on the formal documentation as a source of data.
In this case by the time the review resumed the health visitor had retired and did not wish to take part. A number of maternity service professionals came into contact with Toby's mother through the course of her pregnancy and it was not possible to identify or meet with each of these. Therefore the review was limited to discussions with one community midwife and Toby's GP who saw him on one occasion. A health visitor who was not involved with Toby provided general information about the service and working conditions.
The review had access to the record of a detailed root cause analysis style interview with Toby's health visitor. In addition GP, obstetric, antenatal and postnatal hospital and community midwifery records were made available.

The full SCR has been published and you can read it by clicking this circle



Find the Information Sharing Advice here

Learning

Findings:

- Maternity services in South Gloucestershire are task centred and narrowly focused on maternal and baby health (to the exclusion of fathers and extended family members), which has led to a system where midwives lack the skills and tools to take a holistic view which would enable them to identify underlying vulnerabilities or potential concerns
- Health visitors, community midwives and hospital maternity professionals do not work collaboratively which results in poor information sharing and parent's and children's vulnerabilities and wellbeing not being properly understood or responded to.
- The maternity service is not able to provide continuity of care to the most vulnerable mothers particularly if they have an additional health need which results in no one in the service building up a relationship with them and understanding their vulnerabilities
- In South Gloucestershire there is a tendency for information sharing within health agencies to be ineffectual due to a lack of clarity about why information is being shared, what to do with it and whether the information could be followed up

What Happened Next?

Initially it was assumed Toby was a victim of Sudden Infant Death Syndrome (SIDS). The baby's bedding and sleeping arrangement did not comply with safe sleeping guidance. Both parents presented as having limited understanding of a 5 week old baby's needs and were unable to give a clear history of his care in the hours leading up to his death. After Toby died it was found that his father had a diagnosed learning disability and his mother presented as having some level of learning difficulty.
The subsequent post mortem found Toby had a total of 74 rib fractures some occurring within a range of between four and 48 hours prior to his death, some occurring days prior and some up to two weeks prior to death. There was also evidence of traumatic head injury likely to be consistent with a non-accidental event.

What is happening Now?

The findings and recommendations are being considered collaboratively by the relevant health commissioners and providers who will develop an action plan and report to the Children's Partnership Executive.
The Children's Partnership Executive will monitor the progress of the SCR action plan.